DataTrack 10

Tenth in a series of reports which compile and interpret statistical information of direct concern to life insurance executives - **1982**

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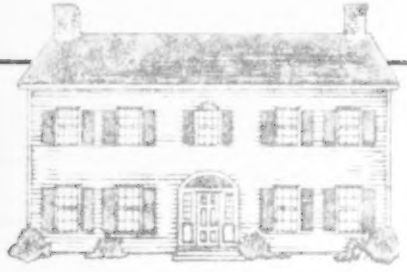

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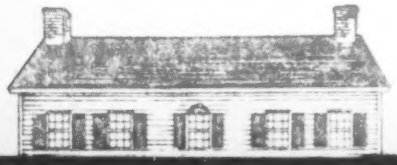


DataTrack 10

Above-Average Income Households and Families

The life insurance product and business are deeply intertwined with a great many aspects of American life. Changes in society will continue to have an impact on the future of the business. The *DataTrack* report series provides concise measures of demographic changes over several decades. Each issue compiles data from a variety of sources—mainly government—on one particular demographic subject of interest to life insurance executives. *DataTrack* can be useful in the design of new products and services to meet changing consumer needs; the selection of new markets and marketing strategies; the formulation of new advertising; the long range planning of corporate strategies; planning for changes in human resources; and public relations generally.

DataTrack 10 profiles households and families with incomes of $25,000 and over. The report summarizes the characteristics of these above-average income households and families: their general characteristics (age, racial and ethnic composition, educational level); their household and family characteristics (size, marital status); information on dual-career couples; economic characteristics; and attitudes towards their financial security. Finally, some questions and implications are raised for consideration by life insurance companies.

Note that *DataTrack 10* contains both household and family data, depending on the availability of the data by income. Information for households and families is not strictly comparable. (See ***Definitions*** section of this report for explanations of "household" and "family.")

The American Council of Life Insurance wishes to acknowledge the contribution of Charlotte Twombly to the preparation of this report.

Contents

Definitions 4

Summary 5

General Characteristics 7

Household and Family Characteristics 12

Dual-Career Couples 16

Economic Characteristics 22

Attitudes 26

Implications for Life Insurance Companies 28

Tables

1 *Family Income, 1960-1981 (in 1981 constant dollars)* 8

2 *Age of Householders, by Selected Income Categories, 1981* 9

3 *Distribution of White, Black and Hispanic Families by Selected Income Categories, 1970-1981 (in 1981 constant dollars)* 9

4 *Median Educational Attainment of Householders 25 Years and Over by Selected Household Income Categories, 1980* 10

5 *Educational Level of Married Couples by Selected Income Categories, 1981* 11

6 *Family Status of Households, by Selected Income Categories, 1981* 12

7 *Types of Families, 1970 and 1981* 13

8 *Sex and Marital Status of Individuals, by Selected Income Categories, 1980* 14

9 *Household Size, by Selected Income Categories, 1981* 15

10 *Labor Force Status of Married Couples, by Income, 1981* 16

11 *Most Important Advantage of Combining Career and Family, 1980* 18

12 *Most Important Disadvantage of Combining Career and Family, 1980* 19

13 *Top Concerns of Dual-Career Couples, 1980* 20

14 *Type of Child Care Arrangement for Children Under 6 Years Old, by Family Income, 1965 and 1977* 21

15 *Type of Money Income, by Selected Income Categories, 1980* 22

16 *Occupation of Householder, by Selected Income Categories, 1975 and 1981 (in 1981 constant dollars)* 23

17 *Households with One or More Members Covered by Employer or Union Pension Plan, by Income, 1980* 25

18 *Households with One or More Persons Covered by Employer or Union-Subsidized Health Insurance Plan, by Income, 1980* 25

19 *Financial Outlook of Americans, by Household Income, 1978 and 1981 (in real dollars)* 26

20 *Future Outlook of Americans, by Household Income, 1981* 27

21 *Importance of Goals for Persons in Families Earning $25,000 or More, 1981* 27

Figures

A *Households, by Total Money Income, 1981* 7

B *Average Number of Persons, Children and Earners Per Family, by Family Income, 1980* 15

C *Labor Force Participation of Married Women 16 Years and Over, by Income of Husband, 1981* ... 17

D *Federal Taxes as a Percent of Family Income, 1960-1982* 24

Definitions

Affluent income

$50,000 or more in household or family income.

Above-average income

$25,000 or more in houshold or family income.

Constant dollar income

Income adjusted for price changes.

Household

All persons who occupy a housing unit, including related and unrelated persons. Households may be grouped into two major types: ***family*** and ***nonfamily.*** A ***family*** household is two or more persons living together who are related by blood, marriage or adoption. A ***nonfamily*** household can be one person living alone or a group of unrelated persons residing together.

Householder

One person in each household is designated as the "householder." In most cases, this is the person, or one of the persons, in whose name the home is owned or rented. If there is no such person in the household, any adult member could be designated as such. This term replaces "head of household," previously used by the Census Bureau.

Summary

More and more households are being counted among the ranks of those earning at least $25,000 a year. *DataTrack 10* looks at the diversity and changes among these above-average income households. In planning for future changes in products and services, life insurance companies may wish to consider the implications of the following *DataTrack 10* highlights on their business.

General Characteristics

- Over 36% of U.S. households, including 44% of all families, made at least $25,000 in 1981.
- During the 1960s, the proportion of families earning $25,000 or more (in constant 1981 dollars) just about doubled, but during the 1970s it remained fairly stable.
- In general, the higher the income, the older the householder; however, householders 65 years and over are underrepresented among the above-average income ranks.
- Proportionately twice as many White families (46.5%) as Black (23.1%) earned $25,000 or more in 1981, the same ratio as in 1970.
- Householders with household incomes of $75,000 or more are the most highly educated of all householders, having completed a median of 16.7 years of school compared to 12.5 years for all householders.

Household and Family Characteristics

- Above-average income households are more likely than others to be comprised of families led by married couples. In 1981, 88% of households earning at least $25,000 were family households and about 93% of these families were led by married couples. In comparison, 73% of households of all incomes were family households and 82% of these families were led by married couples.
- While the proportion of married couple families in the general population dropped from 86% to 82% between 1970 and 1981 and the proportion of families led by women rose from over 11% to 15%, the distribution of the various types of above-average income families remained fairly stable through the 1970s.
- Women who earn $25,000 and over are less likely to be married and more likely to be widowed or divorced than men of the same income.
- Above-average income households are larger than others—not because they have more children but mainly because there are more married couples and fewer one-parent households among them.

Dual-Career Couples

- Married couples with family incomes of $25,000 and above are the most likely of all married couples to be in the labor force.
- The high labor force participation of married women whose husbands earn from $13,000 to $24,999 puts many of these families in the $25,000 and above income bracket.
- Women with pre-school children whose husbands make over $25,000 are not as likely to be in the work force as women whose husbands have lesser incomes.
- Dual-career couples rank "more money" as the most important advantage of combining career and family, and "not enough time together" or "too much to do" as the greatest problems.
- Family is viewed more important than career by both spouses in two-career couples.
- Children of above-average income families were the most likely of any children to use group day care centers in both 1965 and 1977, when the proportion nearly doubled from 9.9% to 18.4%.

Economic Characteristics

- While wages and salaries are the most often cited income sources for all families (83.1%), dividends, interest, rent, estates, trusts and royalties are the most frequently tapped sources for families earning $50,000 or more (93.8%). However, the average income gained from interest and rents, etc., for affluent families is relatively low compared to other income sources.
- Householders in households with incomes of $50,000 and over are 1-1/2 times as likely to be in white collar jobs and half as likely to be in blue collar jobs than householders in $25,000 to $49,999 households.
- Persons in above-average income households are much more likely than others to be covered by an employer or union pension plan and health insurance program.

Attitudes

- Although above-average income Americans feel more financially secure than other Americans, they felt less secure in 1981 than they did in 1978.
- Persons in households with incomes of at least $25,000 are more optimistic about their future than persons with less household income.

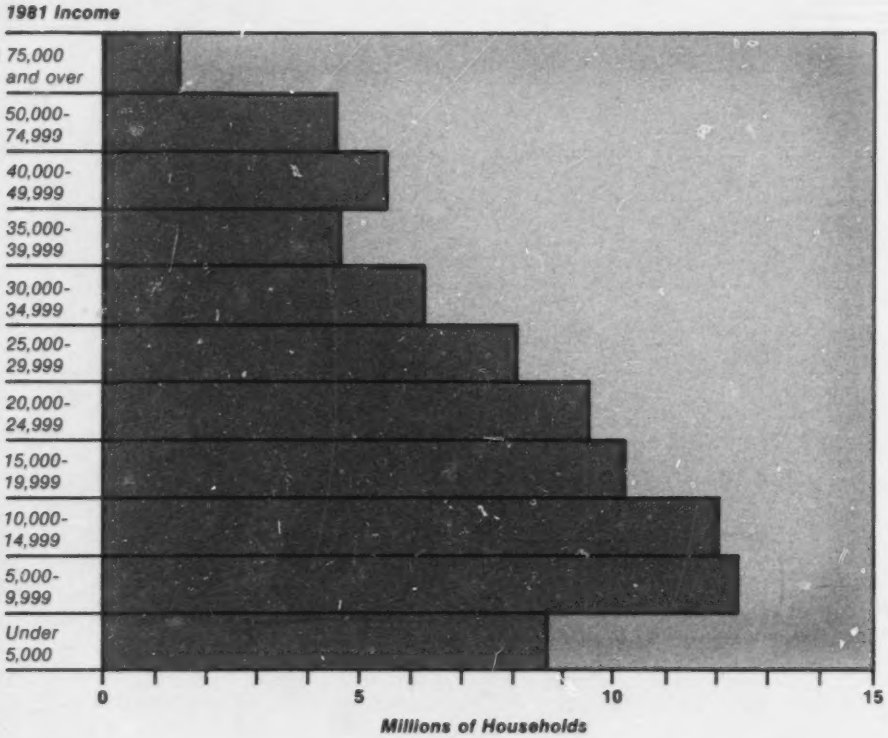
General Characteristics

1. *More than 1 in 3 U.S. households (36.5%) made at least $25,000 in 1981.*

The income distribution of households in Figure A takes into account family households as well as nonfamily households (those with persons living alone or unrelated persons living together).* Nonfamily households—many of which consist of retired persons or others living alone—generally have lower incomes than family households, where there is often more than one wage earner. Mainly because of the tremendous increase (78%) during the last decade of nonfamily households, the income distribution of households in Figure A shows a smaller proportion in the $25,000 and above income categories than does the income distribution of families in Table 1.

Figure A presents the distribution of American households by income in 1981, when the median household income reached $19,074.

Households, by Total Money Income, 1981



SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-60, No. 134.*

*For further clarification of these terms, see "Definitions," page 4.

During 1981, about 30.5 million households earned $25,000 or more. This represents over 98.7 million people. The number of households in the above-average income brackets ($25,000 or more) increased 26% (or over 5.5 million) during the 1970s, at about the same rate of growth as all households.

Between 1960 and 1970, the proportion of American families earning at least $25,000 (in constant 1981 dollars) just about doubled. (See Table 1.) By 1970, 44.2% of all families were in this income bracket, a dramatic increase from 24.7% in 1960. Although the proportion of families earning $25,000 or more (in constant 1981 dollars) remained fairly stable throughout the 1970s, there was a noticeable change in the share making $35,000 and above, from 18.7% in 1970 to 23.8% in 1981.

Family Income, 1960-1981 (in 1981 constant dollars)

Total Money Income	1960	1970	1981
	%	%	%
Under $5,000	10.0	5.2	5.8
5,000 - 9,999	14.3	10.3	11.5
10,000 - 14,999	16.5	12.1	13.6
15,000 - 19,999	23.1	17.6	12.6
20,000 - 24,999	11.5	10.7	12.6
25,000 - 34,999	24.7	25.5	20.2
35,000 - 49,999		11.2	14.9
50,000 and over		7.5	8.9
Total	100.0	100.0	100.0
Median income	$17,259	$23,111	$22,388

NOTE: Percentages may not add to 100% due to rounding.

SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-60, No. 134.*

2. *In general, the higher the income, the older the householder.*

As the household income category increases, a greater percentage of householders fall between 45 and 64 years of age and a smaller proportion are between 15 and 34 years. For example, more than one-half of householders with incomes of $75,000 and over were between 45 and 64 years old in 1981 compared to less than one-fourth of the householders in the $25,000 to $29,999 range.

Not surprisingly, householders 65 years and over are underrepresented among the above-average income ranks. While older people led about 21% of all households in 1981, they headed less than 10% of households with incomes of $25,000 and above.

Age of Householders by Selected Income Categories, 1981

	Percentage of Households with Incomes of						
Age in years	$25,000-29,999	$30,000-34,999	$35,000-39,999	$40,000-49,999	$50,000-74,999	$75,000 and over	All households
15-24	5.5	3.6	2.9	1.6	1.1	0.3	7.3
25-34	29.1	27.9	24.7	19.8	13.3	8.6	23.1
35-44	22.8	26.2	27.3	27.0	26.7	25.3	18.3
45-54	17.5	18.9	22.6	26.7	29.2	30.1	15.0
55-64	15.6	16.1	15.7	18.4	21.7	24.8	15.5
65 and over	9.5	7.3	6.8	6.5	7.9	10.9	20.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

NOTE: Percentages may not add to 100% due to rounding.

SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-60, No. 134.*

3. *Proportionately twice as many White families as Black earned $25,000 or more in 1981, the same ratio as in 1970.*

In 1981, 46.5% of all White families made at least $25,000—almost exactly the same share as in 1970 (figured in 1981 constant dollars).

Distribution of White, Black and Hispanic Families, by Selected Income Categories, 1970-1981 (in 1981 constant dollars)

	Percentage of Families with Incomes of			
Racial/Hispanic Origin of Householder	$25,000 and over	$25,000 to 34,999	$35,000 and 49,999	$50,000 and over
White				
1970	46.4	26.6	11.8	8.0
1981	46.5	21.1	15.7	9.7
Black				
1970	22.9	15.9	5.0	2.0
1981	23.1	13.0	8.0	2.1
Hispanic				
1972*	29.0	19.2	6.7	3.1
1981	27.4	14.4	9.5	3.5

** 1970 data for Hispanics are not available.*

SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-60, No. 134.*

A 5.6% rise in the proportion of White families earning $35,000 or more was offset by a declining percentage of those between $25,000 and $34,999. White, Black and Hispanic families alike shared this pattern but to differing degrees, as seen in Table 3. (See Page 9.)

The percentage of Black families with incomes of $25,000 and greater hovered around 23% during the 1970s, with a 3.1% increase in the proportion earning $35,000 and over. Among Hispanic families, there was actually a slight drop in the percentage earning at least $25,000 a year, from 29% in 1972 to 27.4% in 1981.

4. ***Above-average income householders are the most highly educated of all householders.***

The median number of years of schooling completed by all householders in 1980 was slightly above a high school education—12.5 years. In comparison, the median educational attainment of householders with total household incomes of at least $25,000 ranged from 12.8 years for those with incomes of $25,000 to $29,999 to 16.7 years for those making $75,000 or more.

Median Educational Attainment of Householders, 25 Years and Over, by Selected Household Income Categories, 1980

Household Income	Median Number School Years Completed
$25,000 - $27,499	12.8
27,500 - 29,999	12.8
30,000 - 32,499	12.9
32,500 - 34,999	13.0
35,000 - 37,499	13.1
37,500 - 39,999	13.1
40,000 - 44,999	14.1
45,000 - 49,999	14.6
50,000 - 59,999	15.4
60,000 - 74,999	16.3
75,000 and over	16.7
All householders, 25 years and over	12.5

SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-60, No. 132.*

5. *Striking differences in educational attainment are found among couples in the various upper income levels.*

Affluent married couples together earning $50,000 and above have more years of schooling than couples earning $25,000 to $49,999. In families earning at least $50,000, 56.2% of the husbands and 33.3% of the wives have 16 or more years of schooling. By comparison, only 27.9% of the husbands of families making $25,000 to $49,999 and 18.2% of the wives have completed 16 years of school.

Educational Level of Married Couples by Selected Income Categories, 1981

	Family Income	
Joint Level of Education	**$25,000 to $49,999**	**$50,000 and Over**
	%	%
Both less than 12 years	7.8	2.5
Both less than 12 years	7.8	2.5
Husband 12 years, wife less	4.5	2.0
Wife 12 years, husband less	7.0	3.1
Both 12 years	26.0	14.5
Husband 13 to 15 years, wife less	10.4	7.5
Wife 13 to 15 years, husband less	5.4	4.4
Both 13 to 15 years	5.6	4.4
Husband 16 or more years, wife less	15.1	28.1
Wife 16 years or more years, husband less	5.4	5.2
Both 16 or more years	12.8	28.1
Total	100.0	100.0

NOTE: Percentages may not add to 100% due to rounding.

SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-20, No. 371.*

Household and Family Characteristics

1. The higher the income, the greater the probability that a household is a family household.

Nationwide, 73% of all households are family households. Table 6 shows that 84% of households with incomes of $25,000 to $29,999 are family households compared to over 90% of those earning $40,000 or greater.

Family Status of Households by Selected Income Categories, 1981

Total Income	Total	Family Households	Nonfamily Households		Family Households as a % of all Households in Income Category
			Total	*One Person Households*	
$25,000 to $29,999	8,092	6,808	1,284	933	84.1
30,000 to 34,999	6,315	5,536	779	435	87.7
35,000 to 39,999	4,630	4,134	496	242	89.3
40,000 to 49,000	5,469	4,966	503	214	90.8
50,000 to 74,999	4,547	4,130	417	184	90.8
75,000 and over	1,445	1,302	143	70	90.1
All households with income of $25,000 and over	30,498	26,876	3,622	2,078	88.1

SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-60, No. 134.*

Furthermore, over 9 out of every 10 families who make at least $25,000 are led by a married couple. (See Table 7.) Only a small proportion of above-average income families are maintained by a woman alone (4.7% in 1981) or a man alone (2.7%). This pattern has remained stable over the past decade and stands in contrast to trends in the overall population. Among families of all income levels, for example, the proportion with married couples declined between 1970 and 1981 and the percentage maintained by women rose dramatically. (See Table 7.) The consistency of the above-average income family pattern is largely due to the fact that few families maintained by women have a total money income of $25,000 or above.

Approximately 12% of all households earning at least $25,000 were nonfamily households in 1981 and 57% of these consisted of one person. One-person households are more likely to make less money than other nonfamily households, i.e., those with unrelated individuals. About 3 in 4 nonfamily households earning between $25,000 and $29,999 in 1981 were one-person households compared to only about 1 in 2 nonfamily households making more than $30,000.

Types of Families, 1970 and 1981

Type of Family	1970 All Income Families	1970 Above-Average Income Families*	1981 All Income Families	1981 Above-Average Income Families**
	%	%	%	%
Married couple	86.1	93.9	81.7	92.7
Female householder	11.5	4.0	15.1	4.7
Male householder	2.4	2.1	3.2	2.6
Total	100.0	100.0	100.0	100.0

** A comparable group to the 1981 group was constructed by using 1981 constant dollars and finding the near equivalent to 1981 families with a total income of $25,000 and above. Above-average income families for 1970 consist of those who have a total money income of $10,000 and above. $10,000 in 1970 dollars is equivalent to $23,400 in 1981 dollars.*

***$25,000 and over.*

SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-20, No. 371; Series P-60, No. 80; and unpublished data.*

2. *Women who earn $25,000 and over a year are less likely to be married and more likely to be widowed or divorced than men of the same income.*

When comparing men who earn $25,000 and above per year to women with the same earnings, two divergent profiles emerge. In 1980, 86% of these men were married (with wives present), while only 47% of the women were married (with husbands present).

Table 8 shows only slight differences in the marital status of men among all the specific incomes levels above $25,000. The marital status of men with incomes of $25,000 to $29,999 looks quite similar to that of men earning $75,000 and over.

The marital status of women, however, reflects income-based differences. For example, there is a noticeably higher percentage of married women and a significantly lower percentage of divorced women among those who earn $75,000 and above. And women earning $50,000 to $74,999 are almost twice as likely to be widowed as those making from $25,000 to $49,999. Also, when compared to women earning $50,000 and over, proportionately twice as many women earning $25,000 to $49,999 are single.

Sex and Marital Status of Individuals, by Selected Income Categories, 1980

Men	Individual Income $25,000 to 29,999	$30,000 to 34,999	$35,000 to 49,999	$50,000 to 74,999	$75,000 and Over	All Income Levels
	%	%	%	%	%	%
Single	6.7	6.4	3.0	5.0	5.2	23.9
Married						
wife present	84.1	86.4	89.0	86.2	86.3	64.9
wife absent	2.4	1.8	2.2	3.1	2.1	2.9
Widowed	1.0	0.7	1.7	0.5	1.4	2.5
Divorced	5.8	4.7	4.1	5.2	5.0	5.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
Women						
Single	15.0	19.3	17.8	9.5	8.5	17.4
Married						
husband present	45.8	45.0	50.7	40.0	57.4	58.4
husband absent	3.1	5.6	2.8	3.2	8.5	4.0
Widowed	15.7	15.6	13.6	31.6	19.1	12.7
Divorced	20.4	14.5	15.0	15.8	6.4	7.5
Total	100.0	100.0	100.0	100.0	100.0	100.0

NOTE: Percentages may not add to 100% due to rounding.

SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-60, No. 127.*

3. *Above-average income households are larger than others.*

Households with a total money income of $25,000 and above have a smaller proportion of one- and two-person households and a greater proportion of three- or more person households than those in lower income categories. (See Table 9.)

Figure B shows the positive relationship between family income and family size. But the larger average size of families earning at least $25,000 is not because they have more children. In fact, there are fewer children in above-average income families than in families earning under $25,000 and the average number of children in all families is declining. The larger family size can be explained, in part, by the high proportion of married couple families among above-average income households (as discussed on page 16).

Also, high income families have more earners per family than do others. (See Figure B.) Families with incomes of $27,500 and above in 1980 averaged more than two wage earners each, whereas families earning less had fewer than two wage earners.

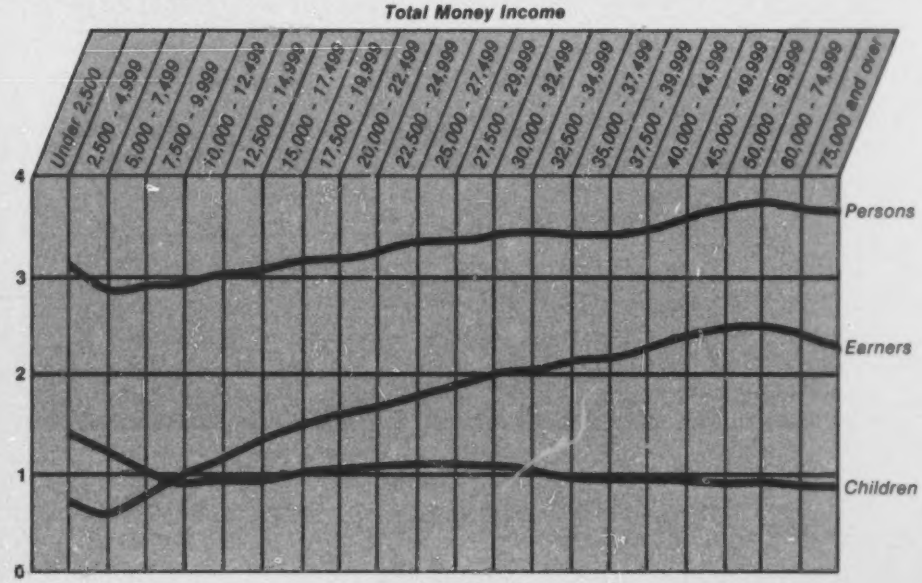
Household Size, by Selected Income Categories, 1981

	Percentage of Households with Income of				
	Under $10,000	$10,000 to $24,999	$25,000 to $49,999	$50,000 and over	All Households
1 person	48.8	21.8	7.4	4.2	23.2
2 persons	27.4	35.7	30.9	29.2	31.7
3 persons	10.6	17.5	22.4	21.8	17.5
4 persons	7.0	14.1	22.5	23.3	15.4
5 persons	3.7	6.5	10.2	12.3	7.3
6 persons	1.3	2.6	4.2	5.5	3.0
7 or more persons	1.3	1.7	2.4	3.6	1.9
Total	100.0	100.0	100.0	100.0	100.0

NOTE: Percentages may not add to 100% due to rounding.

SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-60, No. 134.*

Average Number of Persons, Children and Earners Per Family, by Family Income, 1980



SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-60, No. 132.*

Dual-Career Couples

1. ***Married couples with family incomes of $25,000 and above are the most likely of all married couples to be in the work force.***

The most common labor force participation pattern in above-average income married couples shows both the husband and the wife working or looking for work. Well over one-half of the families in the two highest income categories in Table 10 are composed of dual-earner couples.

In a substantial portion of families earning less than $15,000, neither the husband nor the wife is a labor force participant. Over 98% of these married couples who are not in the labor force have husbands over the age of 45, suggesting that a substantial number are probably retired. Just as dual earning power catapults many couples into the upper income ranks, retirement often removes many couples from this income group. Thus, it is not surprising that only 15.3% of men and 16.4% of women 65 years of age and over are in above-average income families, and only 2.6% of men and 2.3% of women 65 years of age and over have a total family income of $50,000 or more a year.*

Labor Force Status of Married Couples by Family Income, March 1981

	Labor Force Status of Married Couples				
Family Income	**Husband and Wife in Labor Force**	**Husband Only in Labor Force**	**Wife Only in Labor Force**	**Husband and Wife Not in Labor Force**	**Total**
	%	%	%	%	%
Under $10,000	18.1	30.1	5.5	46.3	100.0
$10,000 to 14,999	28.8	35.4	7.1	28.7	100.0
$15,000 to 19,999	42.8	37.4	5.2	14.6	100.0
$20,000 to 24,999	51.0	36.7	4.2	8.1	100.0
$25,000 to 49,999	61.9	30.9	2.7	4.4	100.0
$50,000 and over	55.0	39.0	1.8	4.1	100.0

NOTE: Figures may not add to 100% due to rounding.

SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-20, No. 371.*

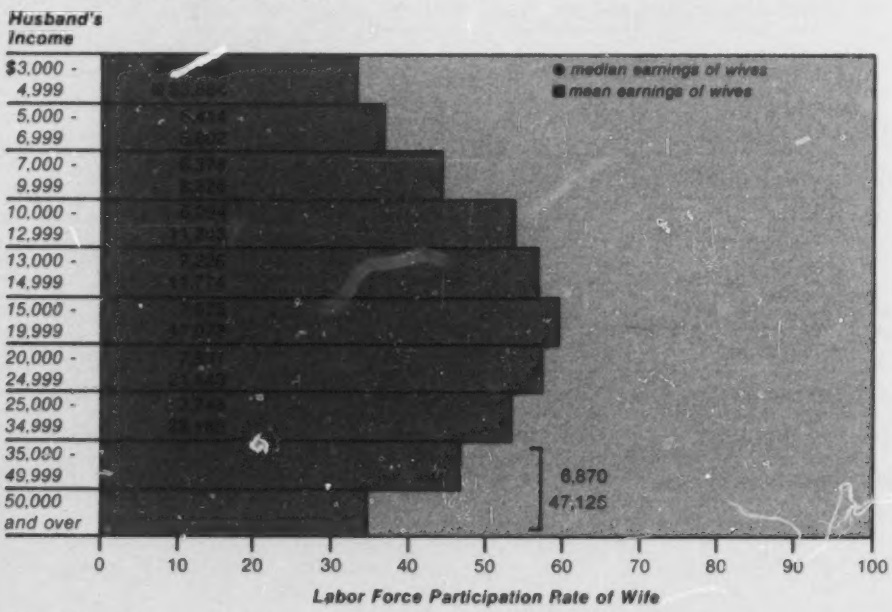
**U.S. Bureau of the Census,* Current Population Reports, *Series P-60, No. 129.*

2. *The high labor force participation of married women whose husbands earn from $13,000 to $24,999 puts many of these families in the $25,000 and above income bracket.*

Married women whose husbands earn between $13,000 and $24,999 annually are more likely to be in the labor force than women whose husbands earn either more than $24,999 or less than $13,000. Looking at both the mean and median earnings for women whose husbands fall into the $13,000 to $24,999 range, Figure C shows that women's earnings are instrumental in creating a substantial number of additional families in the $25,000 and above income category.

Since 1960, the labor force participation rate of married women has increased more rapidly than the rate for women of any other marital status. Contributing strongly to this trend was the growth in working mothers, particularly those with pre-school children. While the labor force participation rate of mothers (husband present) with children 6 to 17 years of age slightly more than doubled between 1950 and 1981 (from 28.3% to 62.5%), that for mothers with children under 6 years of age quadrupled from 11.9% to 47.8%.*

Labor Force Participation of Married Women, 16 Years and Over, by Income of Husband, 1981



SOURCE: U.S. Bureau of Labor Statistics, unpublished data.

*U.S. Department of Labor, Bureau of Labor Statistics, Bulletin 2080. Perspectives on Working Women: A Databook, October 1980 and unpublished data.

A husband's income has an effect on a mother's labor force participation rate. Women with pre-schoolers whose husbands earn over $25,000 have labor force participation rates which are lower than the overall rate for married women with young children, whereas, those with husbands who earn from $7,000 to $19,999 have higher labor force participation rates.

The educational attainment of a married woman has an additional effect on her labor force participation. Regardless of her husband's earnings, the more education a woman has, the more likely she is to be working. However, women with over 16 years of education, whose husbands earn over $50,000, have only a 27.9% labor force participation rate when they have pre-school children.*

3. *Dual-career couples rank "more money" as the most important advantage of combining career and family.*

In a 1980 survey of 815 two-career couples, a plurality of both husbands and wives agreed that "more money" was the most important advantage of combining career and family. Thirty-three percent of the wives and 41% of the husbands ranked "more money"as the top advantage. (See Table 11.)

Most Important Advantage of Combining Career and Family, 1980

	Wives	Husbands
	%	%
More money	33.3	40.8
Autonomy for both	23.2	17.7
Growth	21.1	11.9
More security	6.9	10.1
Self-actualization	4.9	3.3
More in common	3.6	8.5
More freedom	3.4	2.7
More to talk about	1.6	2.2
Children have two parents	0.9	0.7
Children have male and female role models	0.6	0.9

SOURCE: Catalyst Career and Family Center, Corporations and Two-Career Families: Directions for the Future, *New York: Catalyst, 1981.*

**U.S. Department of Labor, Bureau of Labor Statistics, unpublished data.*

While "more money" was the most popular choice for both husbands and wives, wives chose "autonomy for both" and "growth" as second and third in importance while husbands chose "autonomy for both" and "more security."

When asked the most important disadvantages of combining career and family, "not enough time together" and "too much to do" were viewed as the greatest problems. (See Table 12.) Nearly 58% of the wives and 54% of the husbands agreed that one of these time issues was the most problematic area of a dual-career lifestyle.

Most Important Disadvantage of Combining Career and Family, 1980

	Wives	Husbands
	%	%
Not enough time together	33.4	36.8
Too much to do	24.5	16.9
Too much pressure	13.6	9.2
Not enough leisure	8.5	10.0
Insufficient freedom	3.8	4.0
Not enough parenting	3.6	4.3
No one has full-time concern for household	3.4	5.0
We're too self-involved	3.2	5.8
No home backup	2.8	2.2
Other role-conflict	0.7	0.5

SOURCE: Catalyst Career and Family Center, Corporations and Two-Career Families: Directions for the Future, *New York: Catalyst, 1981.*

4. *Family is viewed as more important than career by both spouses in two-career couples.*

When asked, "Right now, in your life, what is the number one concern to you?" 60% of the men and 58% of the women chose family, in a 1980 poll of two-career couples. (See Table 13, page 20.)

Age appeared to have some effect, as married women 36 to 40 years old were the most likely to choose family over career. Women of all other ages had a higher percentage that selected "career" than did men. Younger women (21-30) were as likely to select "career" and "outside interests" as "family" (all 50%). Husbands were more likely to select "outside interests" than were their wives.

When husbands and wives were asked to predict their most likely concern 10 years from now, 68% of the men and 61% of the women

chose family first. Young men (ages 21 to 30) and young women (ages 21 to 25) were the most likely to make that prediction.

Top Concerns of Dual-Career Couples, 1980

	Women	Men
	%	%
Top concerns now		
Family	57.8	59.7
Career	39.3	32.1
Outside interests	2.8	8.2
Total	100.0	100.0
Top concerns 10 years from now		
Family	60.7	68.4
Career	31.2	19.0
Outside interests	8.1	12.6
Total	100.0	100.0

NOTE: Percentages may not add to 100% due to rounding.

SOURCE: Catalyst Career and Family Center, Corporations and Two-Career Families: Directions for the Future, *New York: Catalyst, 1981.*

5. *Above-average income working women are relying increasingly on child care outside the home.*

In 1965, 50.6% of the children of above-average income families with working women were cared for in their own home (half by a relative and half by a nonrelative). By 1977 there had been a decrease in this type of arrangement to 30.7%. A major part of this decline was due to the drop in the proportion of children cared for in the child's home by a person other than a relative. The percentage of children with this type of care arrangement plummeted from 25.3% in 1965 to 9.7% by 1977. In 1977, the majority of the children in above-average income families were cared for outside the home: 36% in another home and 18.4% in group care centers.

While there has been a general shift away from child care in the home to care outside the home or in group centers, this trend has been especially pronounced for children with mothers who are well-educated, working full-time, or with relatively high incomes.* In fact, children in above-average income families were the most likely of any income group to use group care centers in both 1965 and 1977—almost doubling from 9.9% to 18.4%.

**U.S. Bureau of the Census,* Current Population Reports, *Series P-23, No. 117.*

Type of Child Care Arrangement for Children Under 6 Years Old, by Family Income, 1965 and 1977

Type of child care arrangement	1965* $10,000 or more ($28,800 in 1981 dollars)	1977* $20,000 or more ($30,000 in 1981 dollars)
	%	%
Care in child's home[1]	50.6	30.7
By father	(13.3)	(11.3)
By other relative	(12.0)	(9.7)
By nonrelative	(25.3)	(9.7)
Care in another home	26.7	36.0
By relative	(8.9)	(9.1)
By nonrelative	(17.8)	(26.9)
Group care center[2]	9.9	18.4
Child cares for self	—	1.2
Mother cares for child while working[3]	12.9	12.6
Other arrangements	—	1.0
Total	100.0	100.0

1 Data exclude children whose mothers care for them while working.
2 Data are for all types of group care.
3 Data include children whose mother is working at home or away from home.

** Income categories are not strictly comparable.*

NOTE: Percentages may not add to 100% due to rounding.

SOURCE: U.S. Bureau of the Census, Current Population Reports, *P-23, No. 117.*

Economic Characteristics

1. ***While wages and salaries are the most often cited income sources for all families, dividends, interest, rent, estates, trusts and royalties are the most frequently tapped sources for families earning $50,000 or more.***

Nearly 94% of families with incomes of at least $50,000 report money from interest and rents, etc. (See Table 15.) However, the mean income gained from such sources for affluent families is relatively low compared to other income sources. For instance, families with incomes between $50,000 and $59,999 attribute an average of 7% to interests and rents, etc., and 84% to wages and salaries.

Families earning $25,000 to $49,000 are most likely to rely on wage and salary income than any other sources. Almost 96% of such families do so.

Type of Money Income by Selected Income Categories, 1980

Type of Money Income	Percentage of Families with Incomes of $25,000 to $49,999	$50,000 and over	Families of All Incomes
Wages/salary	95.6	92.4	83.1
Non-farm self employment	12.6	21.4	12.0
Dividends/interest, rent/estates/ trusts, royalties	85.0	93.8	69.0
Social security/railroad retirement	12.7	12.6	23.0
Private and government pensions	10.6	13.1	12.3
Alimony, child support, regular contributions, etc.	12.3	12.2	12.1

SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-60, No. 132.*

2. ***Householders with incomes of $50,000 and over are more likely to be in white collar jobs than householders earning $25,000 to $49,999.***

There are dramatic differences in the occupational makeup of householders of various income levels of $25,000 or more per year. Nearly 82% of all householders with household incomes of $50,000 and over worked in white collar occupations compared to 57% of householders with household incomes of $25,000 to $49,999 in 1981. Also, householders in the $25,000 to $49,999 range were more than twice as likely to be blue collar workers than more affluent householders in 1981.

Between 1975 and 1981 there were slight changes in the occupational makeup of above-average income householders. Householders in households with incomes of $25,000 or more shifted somewhat to white collar occupations, following the pattern for all householders in general.

Occupation of Employed Householder, by Selected Income Categories, 1975 and 1981 (in 1981 constant dollars)

Occupation of Householder	Percentage of Households with Incomes of $25,000 to 49,999		$50,000 and over		All Employed Householders	
	1975*	1981	1975*	1981	1975*	1981
White Collar						
Professional/technical	20.5	22.4	33.8	34.3	17.0	15.8
Managers/administrators	18.3	19.2	33.3	32.2	15.0	15.5
Sales	6.4	6.3	9.3	10.9	6.0	6.3
Clerical	7.8	8.6	3.5	4.4	10.0	11.0
Blue Collar						
Craft	22.4	21.3	9.8	9.8	18.8	17.5
Operatives	13.9	12.8	4.2	4.8	15.8	14.1
Nonfarm laborers	3.2	2.8	0.9	0.9	4.5	3.9
Farm Workers	1.6	1.1	3.1	1.0	3.6	2.9
Service Workers	5.8	5.5	2.2	1.8	9.4	9.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

** Income categories for 1975 are based on approximate income equivalent categories using 1981 constant dollars. The category of $15,000 to $29,999 in real 1975 income was converted to a 1981 constant dollar category of $25,350 to $50,699; the 1975 real income of $30,000 and over to a 1981 constant dollar category of $50,700 and over.*

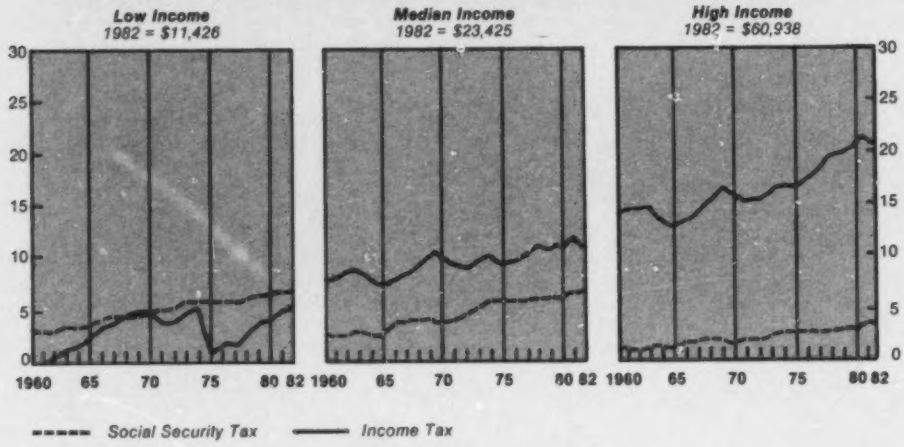
NOTE: Percentages may not add to 100% due to rounding.

SOURCE: U.S. Bureau of the Census, Current Population Reports, *Series P-60, No. 104 and unpublished data.*

3. *Of all families, the affluent are the most taxed by the Federal government.*

Higher income families have been more severely affected by increasing Federal taxes than middle income families. For families earning $60,938 or over in 1982 there has been an increase from 15.1% in 1960 to an estimated 24.4% in 1982 in the proportion of family income which is spent on Federal taxes. For the median income families ($23,425 in 1982) the increase is from 10.7% to an estimated 17.6%.

Federal Taxes as a Percent of Family Income*



*Family income each year at the 20th, 50th, and 95th percentiles of family income distribution.

SOURCE: Eva Culen, ed. "The Two-Way Squeeze, 1982," Economic Road Maps, Nos. 1924-1925, New York: The Conference Board, Inc., April 1982.

4. ***Above-average income households are much more likely to have one or more members covered by an employer or union pension plan than households earning less than $25,000 a year.***

In nearly one-half of all households (47%), at least one member was covered by a pension plan in 1980 provided by an employer or union. The highest proportion of employer or union pension plan coverage (80%) was found among households making between $35,000 to $49,999 in 1980. (See Table 17.)

Employer or union health insurance coverage is also related to household income. In general, the higher the household income, the greater the possibility that a household member is covered by an employer or union-provided health insurance program. (See Table 18.) Households earning between $35,000 and $49,999 in 1980 were most likely to have at least one member covered by an employer or union health plan.

Households with One or More Members Covered by Employer or Union Pension Plan, by Income, 1980

Household Income	Covered by Pension Plan: Number of Households (in 1,000s)	Covered by Pension Plan: Percent of all Households in Income Category
Under $5,000	313	3.2
5,000 - 9,999	1,175	9.0
10,000 - 14,999	4,137	33.8
15,000 - 19,999	5,685	51.9
20,000 - 24,999	6,492	64.8
25,000 - 34,999	9,968	73.4
35,000 - 49,999	6,761	80.0
50,000 and over	3,260	74.1

SOURCE: U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 131 and Series P-60, No. 127.

Households with One or More Persons Covered by Employer or Union-Subsidized Health Insurance Plan, by Income, 1980

Household Income	Covered by Health Insurance Plan: Number of Households (in 1,000s)	Covered by Health Insurance Plan: Percent of all Households in Income Category
Under $5,000	668	6.9
5,000 - 9,999	3,321	25.5
10,000 - 14,999	6,337	51.8
15,000 - 19,999	7,736	70.6
20,000 - 24,999	8,039	80.3
25,000 - 34,999	11,546	85.0
35,000 - 49,999	7,506	88.7
50,000 and over	3,672	83.4

SOURCE: U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 131 and Series P-60, No. 127.

Attitudes

1. ***Although above-average income Americans feel more financially secure than other Americans, they felt less secure in 1981 than they did in 1978.***

It is not surprising that persons living in families with incomes of $25,000 and above feel more financially secure than those with less income. Recently, there has been a downswing of feelings of financial security for all Americans including those families with above-average incomes. A larger percentage of the higher income persons felt somewhat insecure and very insecure (24.4%) in 1981 than in 1978 (20.6%).

Financial Outlook of Americans by Household Income, 1978 and 1981

	*Total Household Income**			
	Under $25,000		$25,000 and Over	
Financial Outlook	**1978**	**1981**	**1978**	**1981**
	%	%	%	%
Very secure	17.0	12.5	32.0	25.3
Somewhat secure	53.4	44.7	47.4	50.3
Somewhat insecure	23.5	28.2	15.8	19.4
Very insecure	6.1	14.5	4.8	5.0
Total	100.0	100.0	100.0	100.0

** In real (current) dollars, not constant dollars.*

NOTE: Percentages may not add to 100% due to rounding.

SOURCE: American Council of Life Insurance

2. ***More than 6 in 10 persons living in above-average income families feel things will improve in the future.***

Sixty-three percent of persons in families making at least $25,000 that were surveyed by the American Council of Life Insurance in 1981 felt optimistic and hopeful about the future and saw the future as bringing improvements to their lives. Ninety-three percent of this same group saw either stability or improvement in their future. Only 6.1% (compared to 13.5% of those in families below $25,000) felt pessimistic about their future and foresaw the possibility of things worsening for them.

Future Outlook of Americans, by Household Income, 1981

Future Outlook	Household Income	
	Under $25,000	$25,000 and over
	%	%
Will improve	53.0	62.6
Will remain as now	33.4	29.9
Will get worse	13.5	6.1
No answer	0.1	1.4
Total	100.0	100.0

SOURCE: American Council of Life Insurance.

3. *Having a happy family life is the most popular primary goal of persons in above-average income families and "making a lot of money" is most frequently ranked the least important goal.*

Nearly 80% of those from above-average income families chose "a happy family life" as the most important of four life goals in 1981. Ninety-three percent made it their first or second choice. The most popular second choice was "the opportunity to develop as an individual" and the most frequent third choice was "a fulfilling career." Seventy-one percent chose "making a lot of money" as the least important of these four choices and 87% chose it as third or fourth in priority.

Importance of Goals for Persons in Families Earning $25,000 or More, 1981

Goal	Rank of Importance			
	First in Importance	Second in Importance	Third in Importance	Least Important
	%	%	%	%
A happy family life	79.3	13.4	3.9	2.3
A fulfilling career	4.4	32.0	49.2	12.7
The opportunity to develop as an individual	14.1	43.8	29.2	11.9
Making a lot of money	1.7	9.4	16.2	71.1
No answer	0.4	1.3	1.6	2.0
Total	100.0	100.0	100.0	100.0

NOTE: Percentages may not total 100% due to rounding.

SOURCE: American Council of Life Insurance.

Implications for Life Insurance Companies

Affluent families today are different than those of several decades ago. There are greater numbers of them and they are more sophisticated. Their affluence is more likely due to combined incomes rather than one wage earner. The demands of career and family make time a much more important factor in their lives. While every ACLI member company needs to consider what these population changes specifically mean for their own products, services and operations, the following are a few questions and broad implications.

- Retirement income planning may become even more important for middle aged and older families as more become accustomed to comfortable living styles. Are companies prepared for increasing opportunities in individual pension markets?
- Wages and salaries are the primary income source for most American families, including those in the above-average income brackets. As more families become accustomed to lifestyle changes that often accompany the entrance of the second family member into the workforce, will there be an increased interest in income protection products or will the second breadwinner be considered the "insurance" policy against loss of income due to death or disability?
- So-called "up-scale" households, especially those with incomes of $35,000 and above, are making up a growing share of all U.S. households. Future success for some life insurance companies may lie in how well target markets such as these are identified and understood.
- The financial needs and preferences of a single-person household with an income above $50,000 are most likely quite different than those of a family household of the same income with two wage earners. How well do we understand the attitudes and preferences of these various affluent groups? Are some more likely to prefer certain products and services like one-stop financial shopping more than others?
- The two-earner family is becoming the new "typical" family form. Often, the income of a married woman can propel a family into an affluent income bracket—a bracket with more complicated finances. With more complicated finances and less time to manage income, the two-earner family has a special need for financial planning services and may be willing to pay for them.

DataTrack 11

Eleventh in a series of reports which compile and interpret statistical information of direct concern to life insurance executives - 1983

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The Public's Health

DataTrack 11—The Public's Health

Just how healthy are Americans? And how has the health of the population changed over the past few decades? These questions are somewhat difficult to answer because most statistical indicators of health focus on sickness, not wellness. However, by looking at data on births, deaths, disease, disability and health habits, *DataTrack 11* draws a picture of an increasingly healthy American public.

The Public's Health is the latest in the series of reports by the American Council of Life Insurance on demographic topics of interest to life insurance executives. Each study compiles data from a variety of sources—mainly government—on issues that will have an impact on society and on the future of the life insurance business. *DataTrack* can be useful in the design of new products and services to meet changing consumer needs, the selection of new markets and marketing strategies, the formulation of new advertising, the long range planning of corporate strategies, planning for changes in human resources, and for public relations generally.

Note that information on health insurance, health care costs, utilization and resources are not included in this issue of *DataTrack*. Persons interested in these aspects of health may want to consult the *Source Book of Health Insurance Data*, published by the Health Insurance Association of America, 1850 K Street, N.W., Washington, D.C., 20006, or the U.S. Department of Health and Human Services' *Health, United States, 1982*.

On the Cover:

This issue of *DataTrack*, "The Public's Health," addresses current health trends in the United States. Various aspects of health are represented on the cover by a bicycler, symbolizing exercise and fitness; caduceus, the staff of Mercury, symbolizing medical care; and Chinese characters symbolizing longevity—a benefit of improved health practices.

Definitions

Abortion rate – The estimated number of abortions in a given year for a specific number of women in the population.

Acute condition – A condition that lasted less than three months and involved either medical attention or restricted activity.

Age-adjusted death rate – The number of deaths per 100,000 population in a certain year, adjusted for differences due to changes in the age composition of the population.

Bed disability day – One on which a person stays in bed for all or most of the day because of a specific illness or injury.

Birth rate – The number of live births for a specific number of the population in a given time period.

Chronic condition – A condition that lasted more than three months or is one of the conditions such as hay fever or epilepsy that are always classified as chronic regardless of the onset.

Crude death rate – The number of deaths, for a specific number of the population in a given time period.

Disability – A general term used to describe any temporary or long-term reduction of a person's activity as a result of an acute or chronic condition.

Incidence rate – The number of persons contracting a disease during a given time period per 1,000 population at risk.

Infant mortality rate – The number of deaths of infants under 1 year old per 1,000 live births in a given time period.

Life expectancy – The average number of additional years a person would live if current mortality trends were to continue.

Maternal mortality rate – The number of women who die as a result of complications of pregnancy and childbirth in a given year per 10,000 live births.

Neonatal mortality rate – The number of deaths of infants under 28 days old per 1,000 live births in a given time period.

Reproductive mortality rate – The number of deaths in a given time period per 100,000 women due to causes related to reproduction, including pregnancy and contraception.

Restricted activity day – One on which a person cuts down on his usual activities for the whole day because of an illness or injury.

Work loss day – A day on which a currently employed person, 17 years of age and over, did not work at least half of a normal work day because of a specific illness or injury.

Contents

Summary 4

Fertility and Infant Health 7

Illness and Disability 14

Mortality 21

Health Habits and Attitudes 30

Implications for Life and Health Insurance Companies 38

Figures

A Birth Rates by Age of Mother, 1950-1980 10

B Legal Abortions, 1973-1980 11

C Infant and Neonatal Mortality Rates, 1950-1981 12

D Life Expectancy at Birth and Infant Mortality Rates, 1900-1981 21

E Crude and Age-Adjusted Death Rates, 1930-1981 23

F Death Rates for Persons Aged 25 to 44, by Leading Causes of Death, 1950-1979 29

G Cigarette Smoking Status, Persons 20 Years and Older, 1965-1980 36

H The Balance Sheet: Family Health Attitudes and Behavior 37

Tables

1 Birth Defects, 1970-1971 and 1979-1980 7

2 Live Births by Place of Delivery and Attendant, by Race of Child, 1975 and 1980 8

3 Teenage Births, by Race, 1970 and 1980 9

4 Infant Death Rates in Selected Countries in the Late 1970s 13

5 Selected Reportable Diseases, 1950, 1970 and 1981 14

6 Acute Conditions, by Type and Selected Characteristics, 1981 15

7 Prevalance of Selected Chronic Conditions/Diseases, 1979 16

8 Disability Due to Chronic and Acute Conditions, by Social and Economic Characteristics, 1981 17

9 Persons Injured, by Sex and Circumstance, 1969 and 1981 18

10 Occupational Illnesses and Injuries, 1973 and 1981 19

11 Life Expectancy at Birth, by Sex and Race, 1960-1981 22

12 Age-Adjusted Death Rates, by Race and Sex, 1950 and 1981 24

13 Reproductive Mortality of Women, by Age Group, 1955-1975 25

14 Death Rates for Selected Violent Causes, 1950-1981 26

15 Death Rates by Age and Sex, 1950 and 1980 27

16 Caloric and Nutrient Consumption, Early 1900s and 1980 30

17 Food Consumption, 1980-81 31

18 Proportion of Children 1 to 4 Years Old Immunized Against Specified Diseases, 1965-1980 32

19 Health Practices, by Sex and Education, 1979 33

20 Self-Assessed Health Status, by Sex and Age, 1979 34

21 Participation in Selected Sports, 1973 and 1982 35

22 Current Drug Use, 1972-1979 36

Summary

There have been many improvements in the health of the population over the last several decades. And patterns of disease and death have changed greatly. But these improvements are full of paradoxes: death rates for cardiovascular diseases have decreased but those for cancer have increased; technology has almost eradicated certain infectious diseases such as measles and polio yet other, deadly health problems like AIDS and toxic shock syndrome are appearing.

DataTrack 11 looks at some of the indicators of the changing health of the American population. The following are some highlights.

Fertility and Infant Health

- One out of 12 babies in the U.S. is born with a birth defect.
- The number of babies delivered by a midwife doubled between 1975 and 1980 but 97% of all births in the U.S. are attended by a physician in a hospital.
- The number of births to girls 19 years of age and under in 1980 was lower than in 1970 but this overall trend masks the upturn in teen child-bearing—especially for 15 to 19 year olds—since 1978.
- The largest recent increase in birth rates occurred among women 30 to 34 years old. The birth rate for these women rose from 52.3 births per 1,000 in 1975 to 61.9 births per 1,000 in 1980.
- In 1980, three out of every 10 pregnancies were terminated by abortions. Since 1973, the number of legal abortions more than doubled from 0.7 million to over 1.5 million per year.
- The death rate for children under 1 year of age in 1982 (11.2 deaths per 1,000 live births) was about one-third the rate of 30 years ago. However, this all-time low infant death rate in the United States is about twice the rate of Sweden.

Illness and Disability

- Some infectious diseases (such as polio, measles and whooping cough) which were still prevalent in the U.S. at mid-century have almost disappeared. Other reported diseases such as leprosy, gonorrhea and Rocky Mountain spotted fever rose dramatically.
- Youngsters—especially those under six years of age—were three times as likely to get respiratory infections and nearly eight times as likely to contract infective and parasitic conditions in 1981 as adults 45 years and over.
- Women are about twice as likely as men to have arthritis.
- The higher the educational attainment of a person, the fewer restricted activity days and bed disability days they have.
- The number and rate of all types of injuries have been increasing for men and women.

- The incidence of occupational illnesses and injuries per 100 workers declined between 1973 and 1981 but the number of work days lost per 100 workers due to these illnesses and injuries increased.

Mortality

- The average life expectancy at birth in the U.S. has risen 57% since 1900, from 47 years to a record of over 74 years in 1981.
- The life expectancy differential between men and women has been widening during the 20th century and racial differences have been narrowing.
- The gains in average life expectancy at birth have far outpaced those at older ages.
- The age-adjusted death rate reached an all-time low of 572 deaths per 100,000 population in 1981.
- The maternal mortality rate plummeted from about 61 deaths per 10,000 live births in 1915 to less than 1 death per 10,000 in 1981.
- Motor-vehicle and other accidents are claiming an increasing proportion of the deaths of children ages 1 through 4.
- Improvements in the survival rates of children with leukemia, especially since 1970, have played a key role in the reduction of the overall mortality rate of school-age children (5 to 14 years old).
- While the rates of natural causes of death have been decreasing for young adults 15 to 24 years old, the rates for violent causes have been on the upswing. Homicide was the single largest cause of death among young minority men and women in 1979.
- In 1950, the greatest killer of adults 25 to 44 years old was heart disease. By 1979, accidents had acquired that notoriety, with heart disease dropping to third place, behind cancer.
- The death rate for men 25 to 44 years old is higher than for women in each major cause of death category except cancer, the leading death cause for women in the same age group.
- Heart disease, still the leading cause of death among middle-aged Americans, took the lives of proportionately fewer 45- to 64-year olds in 1979 than in 1950. The cancer death rate for these adults, however, increased during the last three decades.
- The decrease in the death rate for older women over the last 30 years has been greater than that for men. Cancer was the only major cause of death to increase between 1950 and 1979 for this age group.

Health Habits and Attitudes

- Americans are consuming about the same number of calories daily as they did 70 years ago but from a different combination of nutrients and foods. Today, the average American eats one-third more fat and 17% fewer carbohydrates.
- Since 1975, the proportion of children immunized against childhood diseases has declined.
- A person's education is a key indicator of his or her health assessment and health habits. People with less than a high school education are more likely than others to give their health a low rating.
- The proportion of Americans exercising on a regular basis just about doubled between 1961 and 1980, from 24% to 46%. Regular exercisers are more likely to be male, under 30 years old and living in the Northeast or Far West region of the country.
- Cigarette smoking is on the decline among both sexes in all age categories except that of older women.
- The self-reported use of cocaine among young adults in the U.S. tripled between 1974 and 1979, from 3% of all 18 to 25 year olds to 9%. Also, by 1979, about 7 of every 10 young adults said they had tried marijuana at one time or another.
- Americans are showing a heightened interest in their health, but few are actually practicing preventive health habits.

Fertility and Infant Health

1. One out of 12 babies in the U.S. is born with a birth defect.

Over the past decade the rates of some birth defects per 10,000 births declined while those for others increased, as seen in *Table 1*. In particular, Rh disease, anencephaly, open spine, and cleft palate (with cleft lip) showed noticeable improvement. The rates of patent ductus arteriosus (the failure of opening between the aorta and pulmonary artery to close at birth) and congenital hip dislocation increased dramatically, although much of this increase can be attributed to improved diagnosis and changes in coding categories.

Some birth defects can be traced to specific factors such as heavy alcohol consumption or a virus infection during pregnancy. Others like Down's syndrome are attributable to inherited abnormal genes or chromosomes and may be influenced by the age of the mother. The origin of many, however, is unknown.*

Table 1

Birth Defects, 1970-1971 and 1979-1980

	Number of defects per 10,000 births		
	1970-1971	**1979-1980**	**Mean annual % change**
Rh hemolytic disease of newborn	42.28	15.17	-10.76
Anencephaly (absent brain)	5.45	3.47	- 4.97
Spina bifida (open spine)	7.55	5.10	- 4.26
Cleft palate with cleft lip	6.20	4.29	- 4.01
Hydrocephalus (water on brain)	4.81	4.33	- 1.16
Down syndrome	8.17	7.63	- 0.76
Reduction deformity (underdeveloped or missing limbs)	3.16	3.66	+ 1.63
Ventricular septal defect (hole between lower heart chambers)	4.45	11.34	+10.96
Congenital hip dislocation	7.99	23.85	+12.92
Patent ductus arteriosus (failure of opening between aorta and pulmonary artery to close at birth)	3.96	17.80	+18.16

Source: Birth Defects Branch, Chronic Disease Division, Center for Environmental Health, Centers for Disease Control, unpublished data from Birth Defects Monitoring Program.

*March of Dimes Birth Defects Foundation, Facts/1983.

2. *While 97% of all births in the U.S. are attended by a physician in a hospital, the number of babies delivered by a midwife doubled between 1975 and 1980.*

Statistics on births by race and place of delivery indicate the increasing popularity of midwives, especially within hospital settings. The number of hospital births to Whites attended by midwives more than tripled from 10.1 thousand to 33.7 thousand in 1980. Among Blacks, the use of midwives in hospitals just about doubled from 7.7 thousand to 14.2 thousand.

Another recent trend is the growing incidence of nonhospital births among Whites—up from 18.2 thousand in 1975 to 30.4 thousand in 1980, with those attended by midwives nearly doubling as shown in *Table 2*. Nonhospital births to Blacks actually declined during the same period.

Table 2

Live Births by Place of Delivery and Attendant, by Race of Child, 1975 and 1980

	Number of Births (in thousands)			
	Black		White	
	1975	**1980**	**1975**	**1980**
In hospital*				
Physician	484.4	567.6	2,466.0	2,815.4
Midwife	7.7	14.2	10.1	33.7
Other/Unspecified	10.9	3.4	57.7	19.2
Not in hospital**				
Physician	3.2	2.1	7.8	9.5
Midwife	4.6	1.0	5.1	9.9
Other/Unspecified	0.8	1.3	5.3	11.0
Total	511.6	589.6	2,552.0	2,698.7

**Includes births occurring enroute to or on arrival at hospital.*

***Includes births with place of delivery not stated.*

Source: *U.S. National Center for Health Statistics,* Monthly Vital Statistics Report, *Vol. 31, No. 8, Supplement.*

3. *While the number of births to girls 19 years of age and under was lower in 1980 than in 1970, this overall trend masks the upturn in teen childbearing since 1978.*

In 1980, there were more than 562,000 births to women under 20 years old—16% of all births, down from 656,000 in 1970, but up from 554,000 in 1978. The birth rate for young teens ages 10 to 14 remained fairly consistent throughout the 1970s. The rate for 15 to 19 year olds dropped

considerably between 1970 and 1978 but started creeping upward during the last few years of the decade.

The overall decline in teen births has been more significant for older Black teens than for Whites. However, in 1980 the birth rate for Blacks 15 to 19 years of age was over twice that for Whites. Among younger teens the racial differences are even more pronounced: 4.3 births per 1,000 Black teenagers 10 to 14 years old compared to 0.6 births per 1,000 Whites in 1980.

Table 3

Teenage Births, by Race, 1970 and 1980

	Number of Live Births		Birth Rate†	
Race and Age of Mother	**1970**	**1980**	**1970**	**1980**
All races				
Under 15 years	11,752	10,169	1.2	1.1
15-19 years	644,708	552,161	68.3	53.0
White				
Under 15 years	4,320	4,171	0.5	0.6
15-19 years	463,608	388,058	57.4	44.7
Black				
Under 15 years	7,274	5,793	5.2	4.3
15-19 years	171,826	150,353	147.7	100.0

† *Live births per 1,000 women.*

Source: U.S. National Center for Health Statistics, Monthly Vital Statistics Report, *Vol. 31, No. 8, Supplement, and* Vital Statistics of the United States, *1978, Vol. 1, and 1970, Volume 1.*

Teenagers are more likely to experience various complications of pregnancy than women in their twenties. Poor nutrition, physical immaturity and inadequate prenatal care are major factors contributing to greater health risks for teen mothers and their babies. Teens also have a greater possibility of giving birth to low weight babies than women in their twenties.*

4. The largest recent increase in birth rates occurred among women 30 to 34 years of age.

Women 20 to 24 years old experienced the highest birth rate of all women—115.1 births per 1,000 women in 1980. Between 1975 and 1980, however, the birth rate for women 30 to 34 years of age rose from 52.3 births per 1,000 women to 61.9 births, the greatest increase of any age

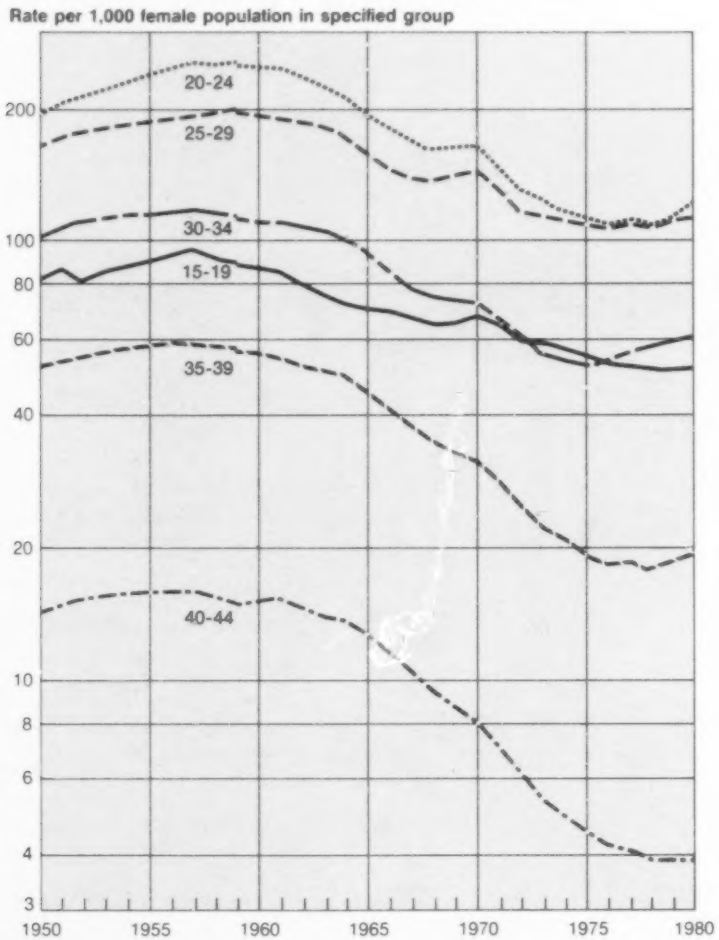
*U.S. Department of Health and Human Services, Health United States, 1980, p. 19.

group. Many of these older women, who had postponed childbearing into their 30's, were becoming mothers for the first time: the first birth rate for women 30 to 34 years increased 60% between 1975 and 1980.*

Women in other age groups showed more modest birth rate changes since 1975 as can be seen in *Figure A*. The rates for women 40-44 years old actually declined between 1975 and 1980.

Figure A

Birth Rates by Age of Mother, 1950-80



Note: *Beginning 1959 trend lines are based on registered live births; trend lines for 1950-1959 are based on live births adjusted for underregistration.*

Source: *U.S. National Center for Health Statistics,* Monthly Vital Statistics Report, *Vol. 31, No. 8, Supplement, 11/30/82.*

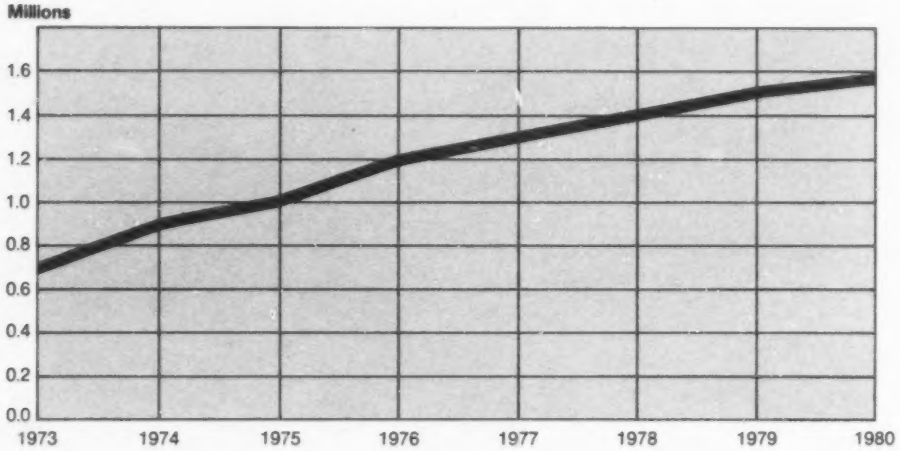
**U.S. National Center for Health Statistics,* Monthly Vital Statistics Report, *Vol. 31, No. 8,* Supplement, *p.4.*

5. In 1980, three out of every 10 pregnancies were terminated by abortions.

In 1973 the U.S. Supreme Court lifted restrictions on most abortions. Since that time, the number of legal abortions more than doubled—from 0.7 million in 1973 to over 1.5 million in 1980. Although the number of abortions in the United States has been rising, the rate of increase has been slowing. Between 1979 and 1980, for example, the number of abortions increased by only 4% compared to a 21% increase from 1973 to 1974.

Figure B

Legal Abortions, 1973-1980



Source: Alan Guttmacher Institute, Family Planning Perspectives, *Vol. 11, No. 6; Vol. 13, No. 1; Vol. 15, No. 1.*

Abortion rates are highest among teenagers—particularly 18 and 19 year olds—and lowest among women over 40 years of age. Race is also a factor: minority women are more than twice as likely to have abortions than White women. However, since 1977, the abortion rate for White women has increased while that for women of minority races has declined. The restriction of Medicaid funding for abortions since 1977 is a major reason for this recent divergence of rates by race.*

6. The death rate for babies under 1 year old in 1982 was about one-third the rate of 30 years ago.

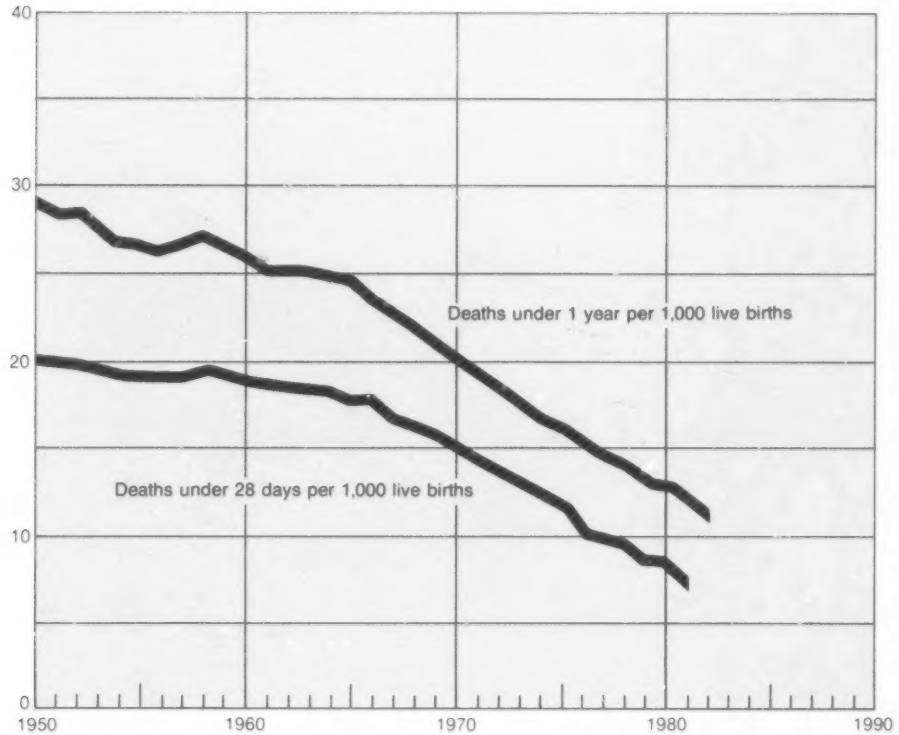
In 1982, there were an estimated 11.2 infant deaths for every 1,000 live births—the lowest infant mortality rate ever recorded in the United States. Looking at the decrease in infant mortality over the last three decades in *Figure C*, there is a noticeable acceleration in the decline since the late

*Stanley K. Henshaw and Kevin O'Reilly, "Characteristics of Abortion Patients in the United States, 1979 and 1980," Family Planning Perspectives, January/February, 1983.

1960s. Some experts attribute this improvement to the increased availability of legal abortion and family planning services.* Other factors contributing to the general drop in the mortality rates of infants during this century have been the greater emphasis on and access to medical and health services for pregnant women and infants.

Figure C

Infant and Neonatal Mortality Rates, 1950-1982



Source: U.S. National Center for Health Statistics, Monthly Vital Statistics Report, *Vol. 30, No. 13.*

The all-time low infant death rate in the U.S. is tempered somewhat by comparisons to other countries, as seen in *Table 4.* In the late 1970s, for example, the infant death rate of Sweden was only about one-half that of the United States.

Within the U.S., race and socioeconomic status are correlates of infant mortality. Although there has been marked improvement in the death

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*M. Grossman and S. Jacobwitz, "Determinants of Variations in Infant Mortality Rates Among Counties of the United States: The Roles of Social Policies and Programs," paper presented at the World Conference on Health Economics, Leiden, the Netherlands, September 8-11, 1980 (as cited in "Legal Abortion, Family Planning Services Largest Factors in Reducing Neonatal Mortality Rate," Family Planning Perspectives, Vol. 13, No. 2, March/April 1981).

rate of minority infants, it is still twice that of Whites (21.8 versus 11.4 in 1979), about the same ratio as 20 years ago. There is evidence that children in low income families are more likely to become ill, suffer adverse consequences from illness and die than other children. Low birthweight, iron deficiency anemia, lead poisoning, hearing disorders, poor vision and other conditions have been found to be more common among poor children.*

A recent survey of public health departments across the nation suggests that infant death rates in some recession-hit areas may be bucking the long-term downward trend. Between 1980 and 1981 the infant mortality rates went up in nine states and in 34 urban and rural areas, including Alabama, Alaska, Kansas, Michigan, Missouri, Nevada, Rhode Island, West Virginia and Wisconsin.**

Table 4

Infant Death Rates in Selected Countries in the late 1970s

	Infant Deaths per 1,000 Live Births
Sweden	7.8
Japan	8.4
Denmark	8.9
England and Wales	13.1
German Democratic Republic	13.2
United States	13.8
Austria	15.0
Israel	17.2
Italy	17.7
Chile	40.1
Uganda	100.5
Ethiopia	150.0

Note: *Death rate for Italy is for 1977; data for Sweden, Japan, Denmark, England and Wales, German Democratic Republic, U.S., Austria, Israel and Chile are for 1978; data for Uganda and Ethiopia are estimated for the period 1975-1980.*

Source: *United Nations,* Demographic Yearbook, 1980 *and* Population and Vital Statistics Report, 1980, *October 1, 1982; and World Health Organization data as reported in U.S. National Center for Health Statistics,* Health, United States, 1982.

**Barbara H. Starfield, "Child Health and Socioeconomic Status,"* American Journal of Public Health, *June 1982, Vol. 72, No. 6*

***Food Research and Action Center, "New Trends in Infant Mortality, A Report," Washington, DC, 1983.*

Illness and Disability

1. Some infectious diseases which were still prevalent among the U.S. population at mid-century have almost disappeared while others have multiplied dramatically.

In 1981, only five cases of diphtheria and six cases of polio were reported to the Centers for Disease Control in Atlanta. This represents an impressive victory for medical research and public health efforts in almost eradicating these infectious diseases. Several other reported diseases also showed large improvements between 1950 and 1981: undulant fever was down 95%; measles, down 99%; and whooping cough, down 99%. Additionally, from 1970 to 1981, the incidence of mumps, rheumatic fever and German measles dropped appreciably, as seen in *Table 5.*

Table 5

Selected Reportable Diseases, 1950, 1970 and 1981

	Numbers of Cases Reported			% Change 1950-1981
	1950	1970	1981	
Measles	319,124	47,351	3,124	- 99.0
Gonorrhea	286,746	600,072	990,864	+ 245.6
Syphilis	217,558	91,382	72,799	- 66.5
Pertussis (Whooping Cough)	120,718	4,249	1,248	- 99.0
Poliomyelitis, acute	33,300	33	6	- 99.9
Diphtheria	5,796	435	5	- 99.9
Brucellosis (undulant fever)	3,510	213	185	- 94.7
Typhoid fever	2,484	346	584	- 76.5
Salmonellosis	1,233	22,096	39,990	+3,143.3
Tetanus	486	148	72	- 85.2
Rocky Mt. spotted fever	464	380	1,192	+ 156.9
Leprosy	44	129	256	+ 481.8
Mumps	(NA)	104,953	4,941	- 95.3*
German measles (Rubella)	(NA)	56,552	2,077	- 96.3*
Tuberculosis	(NA)	37,137	27,373	- 26.3*
Rheumatic fever, acute	(NA)	3,227	264	- 91.8*

**Percent change from 1970 to 1981*

NA = Not available

Source: U.S. Bureau of the Census, Statistical Abstract of the United States 1981 and U.S. Centers for Disease Control, Morbidity and Mortality Weekly Report, *Annual Summary 1981, October 1982, Vol. 30, No. 54.*

A more somber picture is painted by statistics for cases of leprosy, gonorrhea and Rocky Mountain spotted fever which doubled, tripled and quintupled, respectively, over the past three decades. More recently identified health threats such as AIDS (acquired immunity deficiency syndrome)—which has been declared the Number 1 priority of the U.S. Public Health Service—toxic shock syndrome and "legionnaire's disease" also are evidence that the fight against infectious—and deadly—diseases is not over.

2. Acute respiratory conditions are most prevalent among children and among all persons in the North Central and Western parts of the country.

Not everyone has an equal risk of getting the winter flu bug and other acute diseases. Youngsters, for example—especially those under six

Table 6

Acute Conditions, by Type and Selected Characteristics, 1981

	Disease/Condition (Rate per 100 population)			
Characteristic	**Infective and Parasitic**	**Respiratory**	**Digestive System**	**Injuries**
Male	21.4	106.6	9.8	38.9
Female	25.7	116.8	9.5	27.8
Northeast	27.8	100.1	10.5	34.0
North Central	18.3	121.4	6.9	32.4
South	30.6	103.5	10.6	29.4
West	14.1	126.8	11.0	39.7
Inside SMSA	24.2	114.0	10.0	33.1
Outside SMSA	22.4	106.2	9.1	33.3
Under 6 years	59.7	199.3	10.1	36.7
6-16 years	38.0	149.2	15.3	40.3
17-44 years	21.6	111.2	10.6	38.0
45 years and over	7.9	66.4	5.1	21.4
Total Population	23.6	111.9	9.7	33.2

Note: Conditions are classified by type according to the 9th revision of the International Classification of Diseases with certain modifications adopted to make the code more suitable for a household interview survey.

Source: U.S. National Center for Health Statistics, Vital and Health Statistics, *Series 10, No. 141 and unpublished data.*

years old—were three times as likely to get respiratory infections and nearly eight times as likely to contract infective and parasitic conditions in 1981 as persons 45 years and over. The school-age population had a slightly higher rate of contraction of injuries and digestive system conditions in 1981 than other age groups.

Geographic differences are also apparent in *Table 6*. While acute respiratory conditions are more common in the North Central and Western populations, the statistics for infective and parasitic conditions are lower in these Regions that in the Northeast and South. Some of these geographic differences may be due to climate, the age makeup of the population and other socioeconomic factors.

3. There are noticeable differences in the prevalence of certain diseases and chronic health conditions among men and women.

Women are about twice as likely as men to have arthritis. In addition to arthritis, women were considerably more apt than men to experience chronic hypertension and migraine problems and somewhat more likely to suffer from hemorrhoids and heart conditions in 1979. (See *Table 7*.)

A recent study points to the increasing prevalence of chronic conditions among middle-aged and older people. Rising morbidity was

Table 7

Prevalence of Selected Chronic Conditions/Diseases, 1979

	Rate per 1,000 Population	
	Male	**Female**
Anemia	4.8	21.0
Arthritis	87.3	150.4
Diabetes	21.8	26.6
Diseases of the uterus and other diseases specific to women	(NA)	20.1
Epilepsy	4.1	3.3
Heart condition	71.3	80.7
Hemorrhoids	36.1	45.3
Hypertension	95.2	123.9
Migraine	11.8	36.9
Multiple sclerosis	0.2	1.0
Prostate	10.4	(NA)

NA = Not applicable

Source: U.S. National Center for Health Statistics, unpublished data.

found for chronic diseases which often cause death (such as cancer and heart disease) as well as for chronic conditions which seldom cause death (arthritis and chronic sinusitis).*

4. The higher the educational attainment, the fewer days of disability.

Disability rates for both acute and chronic health conditions—as measured by the average number of work-loss days, restricted activity

Table 8

Disability Due to Chronic and Acute Conditions, by Social and Economic Characteristics, 1981

	Number of Days (per person)		
	Restricted Activity	**Bed Disability**	**Work-Loss**
Sex			
Both Sexes	19.1	6.9	4.9
Male	17.3	5.8	4.6
Female	20.7	7.9	5.3
Family Income			
Under $3,000	31.4	11.2	5.4
$ 3,000 - 4,999	38.8	14.7	6.4
5,000 - 6,999	30.7	10.3	6.5
7,000 - 9,999	26.2	9.5	6.1
10,000 - 14,999	18.4	6.4	5.5
15,000 - 24,999	15.5	5.5	5.2
25,000 and over	13.1	4.7	4.2
Educational Attainment			
Under 9 years	41.9	14.5	7.3
9 - 11 years	24.9	8.9	7.0
12 years	18.3	6.0	4.8
13 - 15 years	17.9	6.1	4.6
16 years and over	14.2	4.9	3.1

Source: U.S. National Center for Health Statistics, Current Estimates from Health Interview Survey, 1981, Series 10, No. 141, and unpublished data.

*Lois M. Verbrugge, "Longer Life But Worsening Health? Trends in Health and Mortality of Middle-Aged and Older Persons," paper presented at the Population Association of America meetings, Pittsburgh, Pa., April 1983.

days and bed disability days per person—vary by social and economic characteristics. For example, persons with 16 years or more of schooling averaged about one-third as many days of disability in 1981 as those with less than 9 years of education.

Sharp differences are also found in relation to income. Persons with family incomes of less than $3,000 per year have about three times as many restricted activity and bed disability days as persons in families earning $25,000 and over.

5. The number and rate of all types of injuries have been growing for both women and men.

Women experienced more than 1½ times as many accidental injuries in 1981 than in 1969, an increase of 40% more injuries per 100 women. In comparison, men had 1-1/3 as many injuries, or 18% more per 100 men.

Table 9

Persons Injured, by Sex and Circumstances, 1969 and 1981

	Circumstance of Injury				
	While at work	**Home**	**Moving motor vehicle**	**Other**	**Total**
Number of Persons Injured (in 1,000s)					
1969					
Men	6,968	10,508	1,940	11,931	29,815
Women	1,273	9,173	1,711	7,097	18,897
1981					
Men	9,074	13,388	2,424	17,521	40,053
Women	2,216	13,521	2,595	12,291	30,199
Rate per 100 Persons					
1969					
Men	7.3	11.1	2.0	12.6	31.4
Women	1.2	9.0	1.7	6.9	18.5
1981					
Men	8.4	12.3	2.2	16.1	36.9
Women	1.9	11.6	2.2	10.6	25.9

Note: Excluded from these data are all conditions involving neither restricted activity nor medical attention.

Source: U.S. National Center for Health Statistics, Vital and Health Statistics, Series 10, No. 141 and Series 10, No. 63.

The rates of increase for accidents at home, in moving motor vehicles and at work were about the same between 1969 and 1981. Accidents at home account for the largest number of injuries to both men and women.

6. The incidence of occupational illnesses and injuries per 100 workers declined between 1973 and 1981 but the number of workdays lost due to these illnesses and injuries increased.

In 1973, private sector industries recorded 11.0 occupational injuries and illnesses (including fatalities) representing 53.3 lost workdays per 100 full-time workers. By 1981, the injury and illness rate had fallen to 8.3 per 100 but the number of workdays lost rose to 61.7 per 100 employees.

The construction industry had the highest injury and illness rate in 1981 as it did in 1973. (See *Table 10.*) The mining industry continued to lead the field in number of workdays lost per 100 workers.

According to the government's National Institute for Occupational Safety and Health, lung diseases top the list of occupational illnesses and injuries. The others, in order, are musculoskeletal injuries; occupational cancers; amputations, fractures, eye loss, lacerations and traumatic

Table 10

Occupational Illnesses and Injuries, 1973 and 1981

	Incidence Rate per 100 Full-time Workers			
	Total Cases*		Lost Workdays	
	1973	**1981**	**1973**	**1981**
Private sector**	11.0	8.3	53.3	61.7
Agriculture, forestry and fishing	11.6	12.3	68.0	82.8
Mining	12.5	11.6	119.6	146.4
Construction	19.8	15.1	98.1	113.1
Manufacturing	15.3	11.5	68.2	82.0
Transportation and public utilities	10.3	9.0	82.5	100.6
Wholesale and retail trade	8.6	7.3	37.6	45.3
Finance, insurance and real estate	2.4	1.9	10.2	11.6
Services	6.2	5.0	27.5	35.9

** Includes fatalities.*

*** Excludes farms with fewer than 11 employees.*

Source: U.S. Bureau of Labor Statistics, "News," No. 82-423 and Occupational Injuries and Illnesses in the United States by Industry, *1983, Bulletin No. 1874.*

deaths; cardiovascular diseases; disorders of reproduction; neurotoxic disorders; noise-induced loss of hearing; dermatologic conditions; and psychologic disorders.*

7. Stress and health seem to be related but the nature of the relationship is unclear.

The discipline of sociology pioneered theories of the relationship of social stress and pathologies. There is increasing evidence that stressful events can influence physical and mental health. For example, positive association has been identified between unemployment and mortality rates, cardiovascular disease mortality, cirrhosis mortality, suicide, homicide, mental hospital admissions and imprisonment rates.**

There is also a growing body of research on work environments that suggest that major stressors in organizational settings are associated with physical and mental health problems. For example, clerical workers were found to be especially susceptible to the risk of heart disease in the famous Framingham study. Low rates of job mobility and lack of support from supervisors were high risk factors in cardiovascular disease for clerical workers.†

Other illnesses linked to stress have included peptic ulcers, "spastic colon," atherosclerosis, immune diseases and cancer.†† However, explanations of the association between certain risk factors and disease are inconclusive.

**"Top illnesses related to work named," American Medical News, February 4, 1983.*

***M. Harvey Brenner, "Health Costs and Benefits of Economic Policy," International Journal of Health Services, Vol. 7, No. 4, 1977.*

†*Glen R. Elliott and Carl Eisdorfer (eds.),* Stress and Human Health: Analysis and Implications of Research, *New York: Springer Publishing Co., 1982, pp. 81, 86.*

††Ibid., *pp. 261-275.*

Mortality

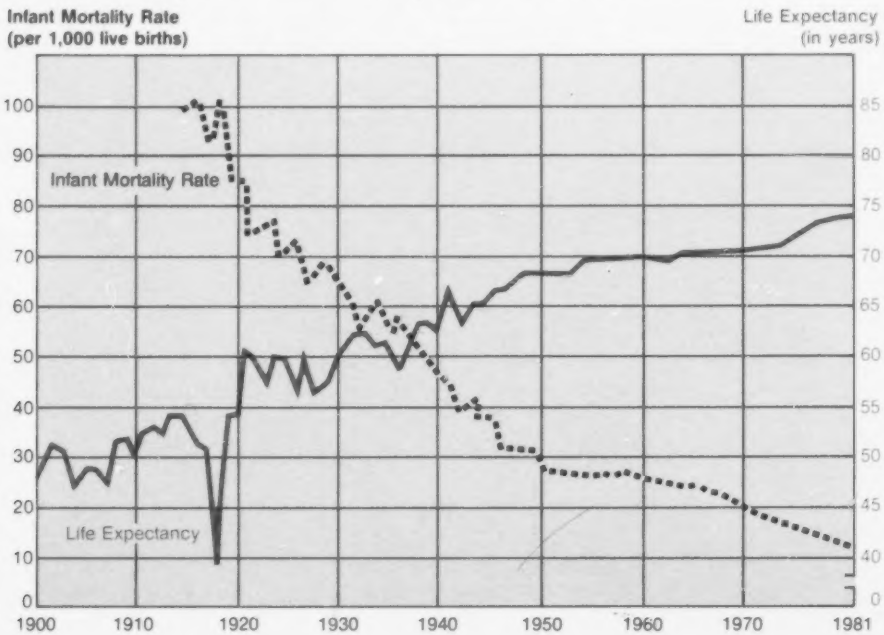
1. The average life expectancy at birth in the United States has risen 57% since 1900, from 47 years to a record of over 74 years in 1981.

The increase in life expectancy at birth over the past eight decades, although quite sizable, has progressed in fits and starts. Between 1910 and 1930 nearly 10 years were added to the average American's life expectancy at birth compared to 2.7 years in the 20 year period between 1950 and 1970. Recently the gains have quickened: from 1970 to 1981 another 3.2 years were added.

The major reason cited for the advances throughout this century is the control of infectious diseases which once caused high mortality among children. If there are fewer people dying at young ages, the statistical average length of life for the entire population will increase. *Figure D* shows that infant death rates fell substantially at the same time that life expectancy increased during the 20th century. Other factors have been: improved antiseptic procedures during maternal delivery, the introduction of prenatal care and improved sanitation—all of which lowered death rates.*

Figure D

Life Expectancy and Infant Mortality Rate, 1900-1981



Source: U.S. Bureau of the Census, Historical Statistics of the United States: Colonial Times to 1970, *Part 1; National Center for Health Statistics,* Monthly Vital Statistics Report, *Vol. 29, No. 13 and Vol. 30, No. 13.*

**Joan Arehart-Treichel, "Life Expectancy: The Great 20th Century Leap,"* Science News, *Vol. 121, March 13, 1982.*

2. *Improvements in life expectancy were not evenly distributed between men and women or among the races. Nor were they uniform for all age groups.*

The life expectancy differential between men and women has been widening during the 20th century. In 1900 women outlived men by 2.0 years; by 1960 the difference was 6.5 years. A baby girl born in 1981 could expect to live 77.9 years compared to 70.3 years for a baby boy—a gap of 7.6 years.

Racial differences in life expectancy are narrowing, as can be seen in Table 11. The closing of the gap between the various races moved especially quickly over the past two decades for women. However, the life expectancy gap between women and men is widening among minorities as it is among Whites.

Table 11

Life Expectancy at Birth, by Sex and Race, 1960-1981

Sex and Race	1960†	1970	1981††
Women, all races	73.1	74.7	77.9
White	74.1	75.6	78.5
Black and other races	66.3	69.4	74.5
Men, all races	66.6	67.1	70.3
White	67.4	68.0	71.0
Black and other races	61.1	61.3	66.1

† *Includes deaths of nonresidents of U.S.*

†† *Provisional data.*

Source: U.S. National Center for Health Statistics, Health United States, 1982; *and* Monthly Vital Statistics Report, *Vol. 30, No. 13.*

The gains in average life expectancy at birth have far outpaced those at older ages. A 65 year old in 1980 could expect to live another 16.4 years compared to 11.9 years at the turn of the century—a gain of only 4.5 years.*

How quickly will the average life expectancy continue to improve in the future and what are the limits to that improvement? Some experts suggest that the average life expectancy will continue to gradually increase but more slowly than in the past. Further increases, according to this point of view, would be due to continued declines in infant death rates and advances in medical science in controlling such conditions as hypertension and reducing the severity and mortality risk of certain

U.S. Center for Health Statistics, Health, United States, 1982.

chronic degenerative diseases like diabetes.* Others argue that there are biological limits on future longevity changes but that more and more people will be surviving to a biologically fixed life span, with chronic disease being postponed by changes in life style.**

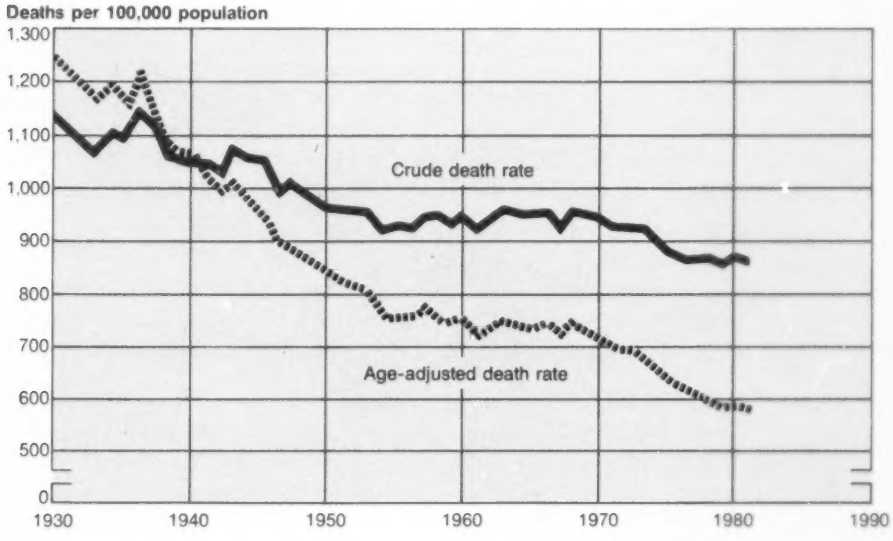
If reductions in the age-specific mortality rate were to continue in the future similar to the pattern established from 1966 to 1976, life expectancy for women would rise to 84.2 years in 2003 and to 74.2 years for men.***

3. The age-adjusted death rate reached an all time low of 572.0 deaths per 100,000 population in 1981.

When the variances in the age composition of the population over the years are taken into account, the resulting "age-adjusted" death rate declined 54% between 1930 and 1981. The death rate fell significantly from the late 1930s to the early 1950s, then leveled off during the 1950s and 1960s before dropping once again in the 1970s.

Figure E

Crude and Age-Adjusted Death Rates, 1930-1981



Note: Data for 1980 and 1981 are provisional.

Source: U.S. National Center for Health Statistics, Monthly Vital Statistics Report, *Vol. 30, No. 13.*

**Kenneth G. Manton, "Changing Concepts of Morbidity and Mortality in the Elderly Population and their Implications for Major Social Programs," unpublished paper. Also, see* DataTrack 9, *"Older Americans," for discussion of the effects of eliminating various causes of death.*

***James F. Fries, "Aging, Natural Death and the Compression of Morbidity,"* The New England Journal of Medicine, *Vol. 303, July 17, 1980.*

****Dorothy P. Rice, "Impact and Implications of the Changing Age Structure on Health Status and Use of Health Care." (Paper presented at a meeting of the Federal Statistics Users' Conference, May 12-13, 1980.)*

Death rates have fallen for both sexes and for all races but not evenly. Age-adjusted death rates for women have decreased at a faster pace than those for men. The rates of women of Black and other minority races fell especially quickly—dropping by 50% over the past three decades.

Table 12

Age Adjusted Death Rates by Race and Sex, 1950 and 1981

	Number of Deaths per 100,000 Population	
Sex and Race	**1950**	**1981***
Women		
White	645.0	403.7
Black and other races	1,106.7	548.0
Men		
White	963.1	731.6
Black and other races	1,373.1	966.5

**Provisional data.*

Source: U.S. National Center for Health Statistics, Health, United States, *1981, and* Monthly Vital Statistics Report, *Vol. 30, No. 13.*

4. The maternal mortality rate plummeted from about 61 deaths per 10,000 live births in 1915 to less than 1 death per 10,000 in 1981.

During the 20th century, great success was achieved in reducing the chance of dying from complications of pregnancy and childbirth. In 1981, the deaths of an estimated 280 women were attributed to such reasons in the United States. Women of Black and other minority races were more than three times as likely as White women to die from these complications.

Another way to assess the changing health status of American women is to look at the number of deaths associated with contraception as well as with pregnancy. The "reproductive mortality rate"—the number of pregnancy- and contraception-related deaths per 100,000 women ages 15 to 44—was cut from 7.8 deaths in 1955 to 2.1 deaths in 1975. (See *Table 13.*) In 1955, pregnancy-related deaths overwhelmingly outnumbered contraception-related deaths 192 to 1. By 1975, the estimated number of deaths due to pregnancy had decreased and those due to contraception had increased so that they were nearly equal.

Table 13

Reproductive Mortality of Women, by Age Group, 1955-1975

	Estimated Number of Deaths		Reproductive Mortality Rate (per 100,000 women)
	Pregnancy-Related	Contraception-Related	
1955			
15-19 years	220	1	4.0
20-34	1,725	8	9.8
35-44	744	5	6.4
Total, 15-44	2,689	14	7.8
1965			
15-19 years	165	2	2.0
20-34	1,031	74	6.1
35-44	489	225	5.7
Total, 15-44	1,685	301	5.1
1975			
15-19 years	76	4	0.8
20-34	352	121	1.9
35-44	99	347	3.8
Total, 15-44	527	472	2.1

Source: Benjamin P. Sachs, MB, BS, DPH(C); Peter M. Layde, MD; George L. Rubin, MB, BS; Roger W. Rochat, MD, "Reproductive Mortality in the United States," Journal of the American Medical Association, Vol. 247, No. 20, May 28, 1982, Copyright 1982, American Medical Association.

5. Homicide death rates have more than doubled since 1950.

On the whole, the death rate due to violent causes increased dramatically during the 1960s but was about the same in 1981 as in 1970. Over the past three decades, however, different patterns have emerged for deaths due to violent causes.

The death rates for motor vehicle accidents (both the crude rate and the age-adjusted rate that takes into account changes in the age structure of the population) have vascillated between about 23 and 27 deaths per 100,000 population from 1950 to 1981. Suicide rates have also fluctuated with the 1981 crude death rate at 12.3 per 100,000, slightly above the 11.4 rate of 1950.

Homicide death rates, however, have increased considerably. In 1950, the crude death rate for homicide and legal intervention was 5.3 per 100,000 population; by 1981 it had more than doubled to 10.7.

Table 14

Death Rates for Selected Violent Causes, 1950-1981

	Number of Deaths per 100,000 Resident Population			
	Motor Vehicle Accidents	**Homicide***	**Suicide**	**Total Death Rate for Violent Causes**
Crude death rate				
1950	23.1	5.3	11.4	39.8
1960	21.3	4.7	10.6	36.6
1970	26.9	8.3	11.6	46.8
1981**	22.8	10.7	12.3	45.8
Age adjusted death rate				
1950	23.3	5.4	11.0	39.7
1960	22.5	5.2	10.6	38.3
1970	27.4	9.1	11.8	48.3
1980	23.7	11.4	12.2	47.3

**And legal intervention.*

***Provisional data.*

Source: U.S. National Center for Health Statistics, Monthly Vital Statistics Report, *Vol. 31, No. 12, and* Health, United States, 1982.

6. Trends in mortality rates differ among age groups.

In 1950 the leading cause of death in the United States was heart disease, followed by cancer, strokes and accidents. Death rates due to heart disease have declined—possibly the result of factors such as decreased smoking, better control of hypertension, increased physical activity, more widespread use of coronary care units and recent dietary improvements. However, despite these improvements, in 1980 heart disease remained the number one cause of death in the U.S. Death rates due to cancer have been on the increase, especially for malignancies of the respiratory system. The death rate for strokes was cut in half over the past three decades, resulting in its drop from the third to the fourth leading cause of death by 1980.

Changes in death rates and causes of death can be better understood when they are described by age, sex and racial differences. The following analysis of mortality trends is organized by six age groups: 1 to 4 years, 5 to 14 years, 15 to 24 years, 25 to 44 years, 45 to 64 years and 65 years or more.

Table 15

Death Rates by Age and Sex, 1950 and 1980

	Deaths per 100,000 population			
	Men		Women	
Age	**1950**	**1980***	**1950**	**1980***
Under 1 year	3,728.0	1,454.8	2,854.6	1,159.3
1-4 years	151.7	74.0	126.7	57.1
5-14	70.9	37.1	48.9	25.5
15-24	167.9	179.6	89.1	57.3
25-34	216.5	205.5	142.7	77.5
35-44	428.8	301.7	290.3	154.1
45-54	1,067.1	778.6	641.5	413.3
55-64	2,395.3	1,844.9	1,404.8	965.0
65-74	4,931.4	4,064.6	3,333.2	2,122.9
75-84	10,426.0	9,405.1	8,399.6	5,840.4
85 and over	21,636.0	16,901.6	19,194.7	13,427.0

** Provisional data based on 10% sample.*

Source: U.S. Center for Health Statistics, Monthly Vital Statistics Report, *Vol. 29, No. 13.*

1- to 4-year-olds

The death rate for children from 1 to 4 years of age dropped 53% between 1950 and 1980, due mainly to reductions in death rates from natural causes such as influenza, pneumonia and leukemia. Accidents take the most lives of young children. In 1979, for example, 41% of all deaths of children ages 1 through 4 involved motor vehicle and other accidents compared with 26% in 1950. At this age, boys have higher mortality rates than girls (74.0 compared to 57.1 in 1980). And statistics for racial minorities (91.7) are much greater than those for Whites (59.9). The racial gap is narrowing for this age group as death rates for Black and other minority races have been improving more quickly than those for Whites.

5- to 14-year olds

The death rate for these school-age youngsters was nearly halved between 1950 and 1980 from 60.1 to 31.5 deaths per 100,000 population. Improvements in the survival rates of children with leukemia, especially since 1970, have played a key role in the reduction of the overall mortality rate for this age group. Motor vehicle and other accidents claim over one-half the total number of deaths in this age group. Accident mortality is considerably higher for boys than for girls.

15- to 24-year olds

The trend line for death rates for young adults over the past three decades has been uneven: down 17% in the 1950s, up in the 1960s, leveling off in the early 1970s, and dropping in the mid-1970s before rising again after 1976. By 1980, the death rate for 15- to 24-year olds was only 7% below its 1950 level. In 1980, the death rate for young men (179.6 deaths per 100,000) stood at triple the rate for young women (57.3). The mortality rate for racial minorities was 21% higher than that for Whites in this age group.

While the rates of natural causes of death have been decreasing for young adults, the rates for violent causes—accidents, homicide and suicide—have been on the upswing. These and other "external causes" of death accounted for 80% of all deaths in this age group in 1979, as opposed to 51% in 1950. While motor vehicle accidents were responsible for most of the deaths of young White adults, homicides were the single largest cause of death among young men and women of Black and other races.

25- to 44-year olds

The death rate for adults 25 to 44 years old has been cut by about one-third since 1950, primarily from declines in heart disease and cancer mortality. (See *Figure F.*) Since 1965, the heart disease death rate for this group dropped 46% and the cancer death rate, 31%. In 1950, the largest single killer of adults 25 to 44 years old was heart disease. By 1979, accidents had acquired that notoriety, with heart disease dropping to third place, behind cancer. There have been significant increases in the homicide and suicide rates for this population, particularly since the 1960s.

Men at this age are twice as likely to die as women. The death rate for men is higher than for women in each major cause of death category except cancer, which is the top cause of death for women.

Black men in this age group are more likely to die from homicide than from any other cause. However, homicide rates for Blacks have been declining since the mid-1970s.

45- to 64-year olds

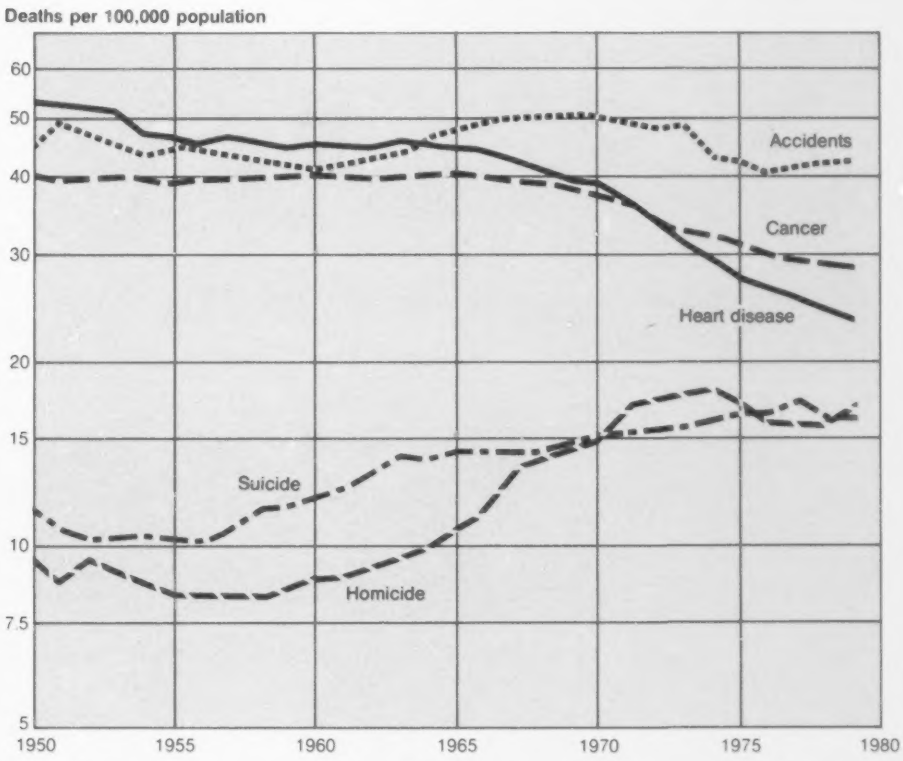
Heart disease, still the leading cause of death among middle-aged Americans, took the lives of proportionately fewer 45- to 64-year olds in 1979 than in 1950. The cancer death rate for these adults, however, increased during this time, especially lung cancer. Presently, men in this age group are three times as likely as women to die of heart disease. Racial differences are most prominent for strokes, where the death rate among Blacks is triple than that for Whites.

Persons 65 years and older

The death rates for older Americans have been on the downswing, with the pace accelerating during the 1970s. The improvement among older women has been greater than that for men. In 1950 the age-adjusted death rate for men 65 years and over was 34% higher than for women; by 1979, the difference was 69%.

Figure F

Death Rates for Persons Aged 25 to 44, by Leading Causes of Death, 1950-1979



Note: Causes of death are assigned according to the International List of Causes of Death. Because of the decennial revisions and changes in rules for cause-of-death selection, there may be some lack of comparability from one revision to the next. The beginning dates of the revisions are 1949, 1958, 1968, and 1979.

Source: U.S. National Center for Health Statistics, Health, United States, *1982.*

Despite a fall in the death rate due primarily to heart disease, this illness continues to claim the lives of the greatest number of older people. Cancer was the only major cause of death to increase between 1950 and 1979.

Racial differences in death rates are smaller among older persons than at any other time of life. In 1980, for example, the provisional death rate for minority men 65 to 74 years of age was only 15% higher than that for White men.

Health Habits and Attitudes

1. The American diet is very different now from that in the early 1900s.

Diet and health are related but the exact nature of the relationship is not completely understood. Six of the 10 leading causes of death have been linked to diet (heart attack, stroke, arteriosclerosis, cancer, cirrhosis of the liver and diabetes).* However, opinions are mixed on just how much saturated fat, cholesterol, or salt is healthy.

Americans are consuming about the same number of calories daily as they did 70 years ago but from a different combination of nutrients and foods. Today, the average American eats one-third more fat and 17% fewer carbohydrates, particularly fewer carbohydrates from starches (as opposed to sugars).

Table 16

Caloric and Nutrient Consumption, Early 1900s and 1980

	Early 1900s†	1980	% Change
Calories per person per day	3,480	3,520	+ 1
Grams of fat per person per day	125	168	+34
Grams of carbohydrates per person per day	492	406	-17
Grams of protein per person per day	102	103	+ 1

† *1909-1913 period.*

Source: Center for Science in the Public Interest, The Changing American Diet, *Washington, DC, 1978 and 1982 update.*

A look at the kinds of foods eaten helps explain the changes in the nutrient composition of the American diet over the last seven decades. (See *Table 17.*) Consumption of fresh fruits is down, while processed foods (canned, frozen) are up. Vegetables have increased in popularity since 1919, especially those canned and frozen. Fresh vegetables, although up overall since 1919, have dropped since the World War II peak of 113.5 pounds per person. Meat consumption has risen, particularly poultry, but recently there has been a decline in beef and veal. Americans are ingesting more caloric sweeteners than ever before; the wholesale sales of sugared soda nearly doubled from $10.4 billion in 1976 to $20.0 billion in 1981.**

*Center for Science in the Public Interest, The Changing American Diet, *Washington, DC, Update, 1982.*

**Ibid.*

Table 17

Food Consumption, 1980-81

	1980/1981 lbs. per person	Changes in Consumption	
		% Change	Years
Apples, fresh	20.0	- 63	1910-1981
Beef and veal	78.8	+ 42	1910-1981
Butter	4.4	- 76	1910-1981
Candy	17.5	- 14	1968-1980
Cheese	22.3	+355	1910-1981
Coffee	10.3	+ 12	1910-1981
Fish, fresh and frozen	7.8	+ 37	1960-1981
Fruit, fresh	87.1	- 35	1909-1981
Milk, whole (gal.)	16.2	- 45	1910-1981
Potatoes, fresh	49.3	- 39	1960-1981
Potatoes, frozen	36.4	+452	1960-1981
Poultry	62.8	+249	1910-1981
Sweeteners, caloric	125.6	+ 33	1909-1981
Vegetables, fresh*	97.0	+ 27	1919-1981
Vegetables, processed*	62.7	+194	1919-1981

** Not including potatoes.*

Note: Based on USDA statistics, the figures reflect food available at the retail level.

Source: U.S. Bureau of the Census, Historical Statistics of the United States, Colonial Times to 1970, *Part 1; Center for Science in the Public Interest,* The Changing American Diet, *Washington, DC, 1982 update.*

2. Since 1975, the proportion of children immunized against childhood diseases has declined.

The introduction of several vaccines has greatly reduced the incidence of childhood diseases that were major health threats in the 1950s and 1960s. Recently, however, proportionately fewer children are being immunized against these diseases.

In 1975, 3 out of every 4 young children (75.2%) received three or more doses of vaccine for diphtheria, tetanus and whooping cough. By 1980, that ratio had dropped to 2 out of 3 (67.5%). A similar decline in immunizations against polio was seen among children 1 through 4 years between 1965 and 1981. Although nearly twice the percentage of children were vaccinated against measles in 1981 as in 1965, the proportion has decreased in recent years. Only German measles and mumps show increasing rates of immunization.

Table 18

Proportion of Children 1 to 4 years old Immunized Against Specified Diseases, 1965-1981

	1965	1975	1981
DPT† (3 or more doses)	73.9%	75.2%	67.5%
Polio (3 or more doses)	73.9	64.8	60.0
Measles	33.2	65.5	63.8
Rubella††	NA	61.9	64.5
Mumps	NA	44.4	58.4

† *Diptheria, pertussis (or whooping cough) and tetanus.*

†† *German measles.*

NA = Not available.

Source: U.S. Centers for Disease Control data as reprinted in U.S. Bureau of the Census, Statistical Abstract of the United States, 1981.

White children are more likely than children of other races to be vaccinated. The racial difference was especially evident for polio in 1979: 64% of White children ages 1 to 4 years and 39% of minority children were immunized. Also, children in central cities—particularly poverty areas—are less likely to have had vaccines.

In a survey of American families taken in the late 1970s most parents did not think that "most childhood diseases have been conquered and there's no need to immunize against them."* Although most parents surveyed thought children should be immunized, a considerable proportion (28%) felt it was the responsibility of the government and/or the schools to innoculate them.

3. A person's education is a key indicator of his or her health habits.

In a government survey of personal health practices, persons with 12 or more years of education had noticeably different health behavior than those who had not graduated from high school.** Less educated people were more likely than others to: give their health a low rating; think they weren't doing a good job of taking care of their health; feel they had less energy and less physical activity than others their age; not see a dentist or have a PAP smear; smoke cigarettes; never wear seat belts; and not brush their teeth regularly or use dental floss.

The survey also concluded that age and sex are related to health and health practices. Older adults 50 to 64 years of age, for example, are more likely to say they have poor or fair health than younger adults and are more concerned about their health. Younger adults, however, were

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*General Mills, Inc., "Family Health in an Era of Stress," 1979.

**U.S. National Center for Health Statistics, Vital and Health Statistics, Series 15, No. 1.

Table 19

Health Practices, by Sex and Education, 1979

	Men, 20-64 years		Women, 20-64 years	
	Less Than 12 Years Education	**More Than 12 Years Education**	**Less Than 12 Years Education**	**More Than 12 Years Education**
Drink a large quantity of alcohol	23.0%	17.4%	4.4%	3.0%
Rarely or never eat breakfast	25.7	26.9	28.2	20.2
Drink 5 or more cups of coffee a day	27.4	22.1	19.4	14.9
Drink less than one glass of fruit or vegetable juice a day	52.6	35.9	43.0	29.5
Drink less than one glass of water a day	9.6	9.8	12.2	9.2
Drink soft drinks in any quantity daily	74.1	74.2	69.8	71.8
Make no effort to limit red meat consumption	82.4	77.1	74.4	63.7
Do not take vitamin supplements	60.9	53.3	49.2	40.7
Average fewer than seven hours of sleep a night	27.2	23.2	24.7	17.5
Brush teeth less than twice a day	66.1	39.8	37.8	17.9
Never floss teeth	71.0	39.3	62.5	26.9
Never use seatbelts	57.2	41.7	58.3	36.3

Source: U.S. Center for Health Statistics, Vital and Health Statistics, *Series 15, No. 1.*

more likely to smoke cigarettes, drink large quantities of alcohol and consume soft drinks.

Men are less concerned than women about their health and are more likely to smoke, drink a large amount of alcohol and coffee and have hazardous jobs.

Table 20

Self-Assessed Health Status, by Sex and Age, 1979

	Poor or Fair Health Status		At Least Some Worry Over Health in Past Year	
	Men	**Women**	**Men**	**Women**
All ages, 20-64 years	16.5%	17.3%	10.4%	7.8%
20-34 years	9.2	10.9	6.9	5.2
35-49 years	16.4	13.5	11.8	8.7
50-64 years	30.4	32.3	14.8	11.8

Source: U.S. Center for Health Statistics, Vital and Health Statistics, *Series 15, No. 1.*

4. The share of Americans exercising on a regular basis just about doubled between 1961 and 1980.

In 1980, 46% of the public said that they do something regularly that helps keep them physicially fit—an increase from 24% in 1961.* College-educated persons in the above-average income brackets, professionals, business people and others in white-collar occupations were most likely to report exercising daily. Regular exercisers were more apt to be male, under 30 years old and living in the Northeast or Far West.**

The most popular sporting activity in 1982 was swimming. (See *Table 21.*) Forty-five percent of Americans surveyed in 1982 reported taking part in this activity one or more times within 12 months before the survey. But swimming seems to be losing a bit of its appeal: 52% reported having swum in 1973. Other activities appearing to be on the slide in popularity include pool and billiards and table tennis.

Boating and snow skiing are among the sporting activities gaining in popularity since 1973. Nineteen percent of the population took part in boating, according to the 1982 survey, up from 16% in 1973. About 1 in 10 Americans (9%) were skiers in 1982, up from 4% in 1973.

A little more than 1 in 7 Americans in the 1972 survey said they jogged or ran. Although no figures are available for 1973, the number of persons jogging declined from 35.7 million in 1979 to 34.3 million in 1982.

**Gallup poll question: "Aside from any work you do, here at home or at a job, do you do anything regularly—that is, on a daily basis—that helps you keep physically fit?"*

***George Gallup, "Motor Boating, Golf, and Bowling Decline As Participation Sports," The Gallup Poll, Thursday, May 15, 1980.*

Table 21

Participation in Selected Sports, 1973 and 1982

Ranking in 1982	Sport	% of Population Participating in Sport†	
		1973	1982
1	Swimming	52	45
2	Bicycling	32	32
3	Fishing	30	28
4	Camping	26	27
5	Boating	16	19
6	Bowling	19	18
7	Physical Conditioning (equipment oriented)	††	15
8	Jogging/Running	††	15
9	Roller Skating	††	13
10	Pool/Billiards	16	13
11	Softball	13	12
12	Tennis	10	11
13	Basketball	11	11
14	Snow Skiing	4	9
15	Table Tennis	16	9

† Not including Armed Forces or persons in institutions or dormitories.

†† Not measured in 1973.

Source: A.C. Nielsen Company, 1982 Sports Participation Survey, News Release, 7/15/82.

5. Cigarette smoking is on the decline among men and women.

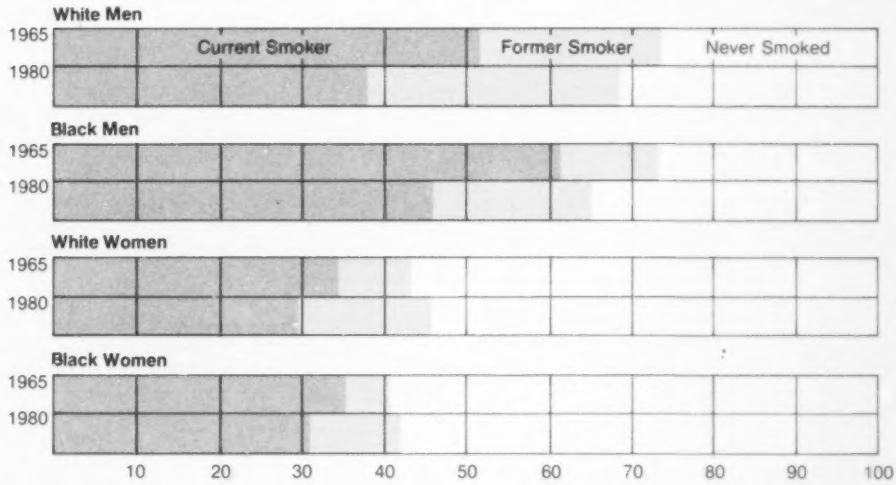
More adults are quitting smoking. From 1965 to 1980 the proportion of current smokers among men over age 20 fell from 52% to 38%. Among women, the percentage of smokers dropped from 34% to 29%. Black men are still more likely to smoke cigarettes than White men although there were proportionately fewer smokers of both races in 1980 than in 1965. The smoking rate for older women (65 years and over) has increased since 1965, contrary to the overall trend.

In 1968, 17% of boys and 10% of girls 12 to 18 years of age smoked cigarettes. Smoking among teens increased from 1968 to 1974 but, since then it has declined. By 1979, however, a greater proportion of teenage girls than boys were smokers.*

*U.S. National Center for Health Statistics, Health, United States, 1982.

Figure G

Cigarette Smoking Status, Persons 20 Years and Older, 1965 and 1980



6. The self-reported use of cocaine among young adults in the United States tripled between 1974 and 1979.

In 1979, over 9% of persons 18 to 25 years of age said that they were current users of cocaine, up from 3% in 1974. Marijuana use has also grown in popularity among all three age groups seen in Table 22. Over one-third of young adults 18 to 25 years old and nearly one-sixth of all teenagers were using marijuana in 1979. About seven out of every 10 young adults said they had tried marijuana at one time or another by 1979.

Table 22

Current Drug Use, 1972-1979

	Youths 12-17 years		Young Adults 18-25 yrs.		Adults 26 years & older	
	1972	**1979**	**1974**	**1979**	**1974**	**1979**
Marijuana	7.0%	16.7%	25.2%	35.4%	2.0%	6.0%
Inhalants	1.0	2.0	*	1.2	*	0.5
Hallucinogens	1.4	2.2	2.5	4.4	*	*
Cocaine	0.6	1.4	3.1	9.3	*	0.9

**Less than 0.5%.*

Source: U.S. Bureau of the Census, Statistical Abstract of the United States, *1981.*

7. Americans are showing a heightened interest in their health, but few are actually practicing preventive health habits.

In a late 1970s survey, 7 out of 10 said Americans are more concerned about health than they were a few years ago.* About the same proportion, however, felt less than well informed about health practices.

Figure H presents a balance sheet of the results of the 1978-79 survey on family health attitudes and behavior. It is a mixture of good news and bad news. While 46% had made lifestyle changes in the interest of good health, 48% said they were cutting back on health practices as a result of inflation.

Figure H

The Balance Sheet: Family Health Attitudes and Behavior

Positive		Negative	
70%	say that most Americans are more concerned about health than they were a few years ago	**44%**	find it hard to cope with the problems of everyday living today
60%	do not take good health for granted	**48%**	are cutting back on health practices as a result of inflation
46%	have made some changes in lifestyles in the interest of good health	**82%**	need less stress in their lives
36%	exercise regularly	**75%**	feel they are in good health without a checkup, so long as nothing bothers them
25%	say they are eating more nutritiously	**54%**	don't want to think that serious illness could happen in their families
26%	are watching calorie intake more carefully than a year ago	**76%**	are confused about all the government health warnings
76%	of parents find it easy to communicate with their families about health	**73%**	feel checkups cost too much for the average family
80%	welcome more openness about mental illness	**75%**	think doctors' fees have risen more than other things
79%	welcome more openness about alcoholism	**57%**	do not recognize depression as a health problem
75%	have a lot of confidence in their doctors	**67%**	do not recognize alcoholism as a health problem
80%	feel they should set an example for their children in health matters	**72%**	are less than well informed about health practices
80%	recognize the dangers of overmedication		

Source: General Mills, Inc. The General Mills American Family Report, 1978-1979, *"Family Health in an Era of Stress." (Conducted by Yankelovich, Skelly and White, Inc.)*

**General Mills, Inc.*, The General Mills American Family Report, *1978-79, "Family Health in an Era of Stress."*

Implications for Life and Health Insurance Companies

Changing fertility patterns, longer life expectancies, changing disease patterns, declining mortality, improved diet and health awareness all will have a profound effect on the future health of the American population. These trends will also have an impact on underwriting techniques, product pricing, pension planning and other corporate decisions. Here are a few questions and implications for consideration by life and health insurers.*

Underwriting

- How will the changing patterns of disease and mortality affect underwriting policies? Will present techniques used to appraise insurance applicants, e.g., blood pressure and build, become outmoded as cardiovascular mortality rates among younger people decline? Will better indicators of physiological age be developed as the result of the "biomarkers" research now being done by some laboratories? More life and health insurers are considering lifestyle factors in their underwriting practices; thus, the connection between lifestyle and health will need to be better understood. As non-accidental mortality declines, medical underwriting may be less usual for certain people, particularly those under 50 years of age.

Work and Retirement

- For the annuity business, changes in mortality trends and economic trends have particularly significant financial consequences. Although interest rates appear to have a more direct, short-term impact on pension costs than mortality trends, corporations should begin to think about what lies ahead. For instance, are companies prepared for the courts to eventually outlaw freezes in retirement benefits for workers after age 65? Also, firms may need to develop strategies for phasing out early retirement inducements.
- A lengthening life expectancy means a greater number of years to plan for financially. Innovative arrangements such as the "reverse annuity mortgage" may become more common income sources in the years ahead.
- As a result of improved longevity, early retirement trends may reverse. More older workers may want to move on to second or even third careers. New careers and responsibilities may lead to renewed needs for income protection products. Life insurers may need to liberalize under-

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**For further discussion of the implications of a longer life expectancy on the life and health insurance business, see* The Future of Life Expectancy, *proceedings of a symposium, March 10-11, 1980 jointly sponsored by the Society of Actuaries, the Association of Life Insurance Medical Directors of America and the Home Office Life Underwriters Association. The panel, "Implications of Changing Mortality Patterns—Industry Impact," with Dr. James Hickman, Dr. Paul Entmacher and Alan Ferguson, is especially relevant.*

writing policies and may have to develop new underwriting techniques for older persons.

- As the older portion of the population grows dramatically (particularly in the early 21st century when the postwar baby boom generation reaches retirement age), the working population may become increasingly unable and unwilling to support this older group through Social Security and other social insurance programs. In areas of the country where young racial and ethnic groups are increasing significantly, will there be a growing reluctance by these minorities to support an aging White population? As social insurance program funding is drained by a rapidly increasing older population, will living standards for older Americans deteriorate to an extent that mortality will be affected?
- There has been increased attention to and concern with perils in the workplace. More employers may become involved in screening and monitoring potential victims of occupational diseases. New coalitions of labor and environmental groups may form to press for greater employer responsibility for toxic substance labeling, identification of possible occupational health threats to workers, and other occupational safety issues.
- Future public health efforts may focus more on environmental health issues. Occupational health services may become an important part of environmental control by government agencies. As more new chemicals are created, what will be their impact on health and the environment?
- Occupational stress may grow as a cause of worker disability. According to *Dun's Business Month,* more than 15 states have approved benefits in cases of disability stemming from job stress. In some cases, worker's compensation boards have been circumvented by civil suits aimed directly at companies. These trends would eventually result in higher insurance rates.

Changing Roles and Lifestyles of Women

- The incidence of reported severe disability is greater among women than men and, on the average, appears at a younger age for women. With more women working outside the home and more women heading families, the economic ramifications of disability among women are substantial.
- If more women decide to postpone childbirth until later in life, there may be a higher incidence of birth defects and low birth-weight infants. Increased teenage childbearing would also put more mothers and infants in high medical risk situations. Advances in neonatal medical technology have dramatically improved the chances of a high-risk infant's survival. These trends could lead to significant increases in health care costs, especially in light of the "Baby Doe" ruling by the U.S. Department of Health and Human Services that would prohibit withholding food and medical care from severely handicapped newborns.

- The growing use of midwives and the increase in nonhospital settings for births have implications for health cost savings. As more states include midwives in their definition of "licensed practitioner of the healing arts," health insurance coverage of these services will increase.
- What will be the effects of changes in women's lifestyles on the widening mortality gap between men and women? The impact of women smoking and working on female mortality rates will be important for insurers to monitor as women seek larger amounts of insurance.

Life Insurance and Improved Longevity

- As premium rates for life insurance drop with declining mortality, there will be greater attraction for policyholders to replace existing policies to obtain the advantage of lower current rates.
- If the likelihood of dying at early ages is reduced by improved technologies, the need for life insurance to guard against the risk of premature death would decline. The need for savings, however, would still exist.
- As deaths due to nonaccidental causes become less common for young and middle-aged adults, will there be less interest in total life insurance and more in accidental death insurance?

Health Insurance and Improved Longevity

- Will anticipated improvements in mortality be accomplished by relatively low cost means such as wellness programs and lifestyle changes or by costly high technological surgical and genetic break throughs? Future health costs will be affected.
- How will the "death with dignity" movement affect future mortality trends and health costs?
- As longevity increases, major health concerns will focus on chronic diseases. In turn, this could lead to escalating costs for health care and greater pressures on social insurance programs. Will government need to set priorities on rationing health care? If so, will longevity improve as much as anticipated?
- As life expectancy increases and the population ages, the total health care costs will increase substantially.
- More people will need long-term care in the years ahead. Present health care financial systems do not provide for extensive custodial care. A current controversial government proposal calls for families of nursing home patients to foot part of the bill. Perhaps public and private sector insurers and health care providers could work together on solutions to long-term care financing problems.
- A growing number of accidents heightens the problem of duplicate payments. There is a need for an appropriate mechanism to prevent duplication of payments.

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